ISDA Illinois School District Agency

ISDA STUDENT ACCIDENT CLAIMS ADMINISTRATOR

STUDENT ACCIDENT CLAIM FORM

Please follow the time frames listed below and submit to the ISDA Claims Administrator by the required due dates.

1. **Claim Form must be submitted no later than 90 days after the date of injury,**
2. **Itemized bills must be submitted no later than 90 days after the date of treatment, and**
3. **Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.**

Items #1, #2, and #3 must be submitted to the ISDA Claims Administrator if the Parent or Guardian has other insurance

INSTRUCTIONS

PLEASE RETAIN A COPY FOR YOUR FILES

1. **The Insured's School must complete the application.**
2. **In case of dental injury, the treating dentist must complete the Student Accident Dental Services Form (below).**

NOTICE OF INJURY FROM SCHOOL (Please PRINT)

Name of School and School District _____

Address of the School District (including city, state, and zip code) _____

Name of School Official Reporting Injury _____ School Contact Phone _____

Name of Student _____ Grade of Student _____

Name of Person supervising activity _____ Name of additional witness if any _____

Date of Injury_____Time_____AM/PM

The injury occurred while the student was participating in: **(please CHECK ANY THAT APPLIES)**

INTERSCHOLASTIC SPORTS Football _____ **Game** _____ **Practice**_____ **Name of Sport** _____

ACTIVITY Travel to/from School _____ **Recess** _____ **Physical Education** _____ **Classroom** _____ **School Grounds** _____ **Other** _____

Please specify Other Activity _____

Part of the body injured _____ Right/Left side _____

Describe how injury happened (**Please BE SPECIFIC**):

_____

_____

Name of Parent or Guardian_____ Parent or Guardian Contact Phone_____

Home Address (including city, state, and zip code) _____

Signature of School Official _____ Title _____ Date _____

NOTICE: Anyone who knowingly misrepresents or falsifies material information requested in this Claim Form may invalidate coverage upon such finding.

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STUDENT ACCIDENT DENTAL SERVICES FORM

TO BE FILLED OUT BY THE TREATING DENTIST

Date of Injury_____ If a Prosthesis is required, is this an initial placement?_____

Was the tooth/teeth sound prior to the current treatment? YES/NO _____

NAME OF DENTAL INSURANCE PLAN _____

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
			TOTAL FEE

_____ _____

Print Dentist's Name Dentist's Signature

_____

Street Address

_____

City State Zip

_____

Date

FEDERAL TAX ID NUMBER (REQUIRED FOR PROCESSING)