

1. What is Project Insurance?

Project Insurance is a secondary medical and accidental death & dismemberment policy that is intended to augment the your own primary medical insurance through school, parents, or yourself. If you do not have any existing insurance coverage then Project Insurance would serve as your primary policy.

Please be aware that it is limited in scope; the *Project Participant should be prepared to pay up front*, with cash or credit card, for any emergency medical expenses that may arise. You would then file a claim for reimbursement with your own health insurance company and/or Chartis.

2. What does it cover?

Plan Provisions:	
Eligibility	All Non-Staff Participants in domestic or international summer projects.
Principal Sum – AD&D	\$12,500
Primary Coverage:	
Accident Medical	\$2,500
Emergency Sickness	\$2,500
Dental	\$100
Deductible	\$25
Excess Coverage:	
Accident Medical	\$27,500
Emergency Sickness	\$27,500
Deductible	\$1,000*
Maximum Benefit:	\$30,000

*If excess coverage is required you will pay \$25 for the first \$2,500 of expenses and either the \$1,000 deductible or the balance of medical expenses (whichever amount is less). Your maximum liability is \$1,025 for coverage up to policy limits.

EXAMPLE 1:

If you incur \$1,500 in medical expenses you will pay only \$25.

EXAMPLE 2:

If you incur \$2,900 in medical expenses you will pay \$425 – \$25 for the first \$2,500 plus the remaining \$400 because the balance is less than the excess coverage deductible amount.

EXAMPLE 3:

If you incur \$4,500 in medical expenses you will pay \$1,025 – \$25 for the first \$2,500 plus the \$1,000 deductible because it is less than the balance (\$2,000).

3. Chartis Policy Number & Contact Info:

Policy Number: SRG0009112988

Claims Number: (800) 551-0824 / (302)661-4176 / Fax (866)893-5984

Claims Address:

Chartis
Accident & Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987

How to File a Claim

READ BEFORE PROCEEDING!

- ? If you have medical coverage under another policy, **your own policy would provide primary coverage.** That means that you must submit the bills to your primary insurer first. Upon receipt of the Explanation of Benefits statements (EOB's) from your primary carrier, **you will file a claim with CHARTIS for excess coverage.**

- ? **If you do not have medical coverage under another policy, the CHARTIS Project Participant policy would provide your primary coverage.**

Filing a claim with Chartis:

1. Complete the form (on next page) - it contains three sections:
 - **Section A** must be filled out by your Project Director or other Project Leader on your behalf. The Project Director or Project Leader must place their signature at the end of the section.
 - **Section B** must be completed by you, the participant (claimant)
 - **Section C** – Do Not Complete This Section – *It will be completed by the health care provider, a process initiated by Chartis.*

2. Collect itemized insurance billing forms* or medical receipts. These forms are available from the health care provider and should include the patient's name, condition (diagnosis), type of treatment and date the expense(s) was/were incurred. Balance due statements are not acceptable.
*HCFA 1500 Form for physicians, UB92 Form for facilities, i.e., hospitals

3. Make copies of all forms and receipts for your records.

4. Mail the completed form and all necessary receipts to:

**Chartis
Accident & Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987**

General Claims Questions?

Contact Risk Management Claims
Coordinator:
407-826-2152

Check Claim Status?

Call Chartis Customer Service:
1 (800) 551-0824

National Union Fire Insurance Co of Pittsburgh, Pa
 Chartis
 Accident & Health Claims Department
 P.O. Box 25987
 Shawnee Mission, KS 66225-5987
 800-551-0824/302-661-4176 - FAX 866-893-5984

PROOF OF LOSS

NAME OF GROUP:

POLICY NUMBER: SRG0009112988

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

- 1.) **You must have SECTION A fully completed by a designated official of the Policyholder.**
- 2.) **SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.**
- 3.) **Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED		

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)

DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY INDICATE THE SPORT (IF APPLICABLE)	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	B. DURING SPONSORED ACTIVITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	C. DURING PROGRAMMED HOURS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS	
POLICYHOLDER REPRESENTATE NAME(PLEASE PRINT)	SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DAYTIME TELEPHONE NUMBER	DATE

SECTION B - MUST BE COMPLETED

DO YOU HAVE OTHER HEALTH INSURANCE Yes ___ No ___

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #
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IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER
NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE # ()

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE

DATE

