Accident Insurance Claim Form

Insurance coverage is underwritten by StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978).

Program administered by Buddy Technology Inc. Claims administered by Co-Ordinated Benefit Plans.

MAILING THE CLAIM

Mailing the Claim
Please return your scanned, completed and signed claim form and all required documents to BAHClaims@cbpinsure.com:

Co-Ordinated Benefit Plans
O/B/O StarNet Insurance Company
PO Box 21282
Tampa, FL 33623

If you choose to mail your documents, please send a copy of your documents and retain the originals for your records. Co-Ordinated Benefit Plans is unable to return any submitted documents. Upon receipt, your claim will be thoroughly reviewed. It may be necessary for Co-Ordinated Benefit Plans to request additional information before a final determination is made.

Documents may also be faxed to the claims office at **(800) 561-8084**. Should you have any questions, please contact our office at **(866) 2245878**.

PLEASE NOTE: Claim Forms Must Be Submitted Within 90 Days Of The Date Of Accident.

PART A – Claimant Details

1. Policy Number:	
2. Policyholder Full Name:	
3. Policyholder Address: (Street) (City) (State) (Zip Code)	
4. Policyholder Date of Birth: Month Day Year / /	5. Policyholder Email Address:
6. Policyholder Phone Number:	

PART B – Claim Details - This part MUST be completed, dated, and signed by the Injured Person, or by Injured Person's Parent or Guardian if he/she is under age 18 or otherwise dependent

1. Print Full Name of Person Completing Form:

Please provide the following information about the Injured Person:

2. Full Name of Injured Person:

3. Date of Birth: Month Day Year / /	4. Gender: ☐ Male ☐ Female	5. Phone Number:

6. Address: (Street) (City) (State) (Zip Code)

7. Date of Accident:

8. Where did the Accident or Injury Occur?

9. Explain how the Accident or Injury occurred:

10. What injuries did you sustain?

11. Did anyone witness the Accident or Injury? ☐ Yes ☐ No

If Yes, please provide:

Full Name:

Phone Number: ( ) Email Address:

12. Attending Physician, if known:

Full Name:

Address:

Phone Number:

13. If treated at, or admitted to, a Hospital:

Full Name of Hospital:

Address:

Phone Number:

PART C – Attending Physician's Statement (To Be Completed by the Attending Physician) - This part MUST be completed, dated, and signed by the Attending Physician, Physician's Office or Applicable Hospital Representative

1. Full Name of Patient:

(First, Middle, Last)

2. Date of Birth:
Month Day Year
/ /

3. Gender:
☐ Male
☐ Female

4. Date of Accident Causing Present Loss:
Month Day Year
/ /

5. Date first consulted on account of the injury described:
Month Day Year
/ /

6. Date of last treatment for this condition:
Month Day Year
/ /

7. Describe the exact nature, location, and extent of all injuries sustained:

8. Was the injury described solely responsible for the loss? ☐ Yes ☐ No

If not, give the particulars of any contributing cause or causes:

9. Where is, or was, the patient being treated? ☐ Urgent Care ☐ Hospital Emergency Room

10. If the patient was admitted to a Hospital as a result of this injury, please provide:

Name of Hospital:

Address:

Date and Time of Admission: Date and Time of Discharge:

Signature of Attending Physician (Required) Date:

Print Name of Attending Physician:

Phone Number:

Authorization to Release Medical Information:
I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company or StarNet Insurance Company, or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I understand that my authorized representative or I will receive a copy of this authorization upon request.

Warning: 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. (Fraud language varies by state, for **New York** see the following, all other state specific states, please see below)

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 or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

☐ Injured Person ☐ Parent ☐ Guardian

Name of Responsible Party: _____

Signature of Responsible Party: _____ Date: _____

*__Attention California Residents__ - Please view our California CCPA Notice regarding collection of Personal Information at the following location: https://www.berkley.com/privacy#californiaConsumerPrivacyPolicy

FRAUD WARNING NOTICES

For residents of Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a

statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of Kentucky: 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.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio and Oklahoma: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.