ESIS®

Personal Accident Claim Form

Please mail your completed Claim Form along with the items listed below to:
(To expedite your claim, please fax it with readable receipts.)

ESIS Specialty Claims
PO Box 6802
Scranton, PA 18505-0556

(844) 756 5571 Inside USA
(248) 368 0577 Outside USA
(248) 440 7626 Fax
ESISA&H@esis.com

Thank you for notifying us of your claim. Please complete ALL questions. If any question is not applicable, please state N/A.

In addition to the Claim Form, please 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 select the benefit for this Accident/Illness:

Participant Accident	☐	Hospital Accident (HAP	☐
Supplemental Health	☐	Out of Country Medical	☐

Section A: Policyholder / Insured Person and Claimant Information

Name of Group (if applicable):

Policy Number: _____ Group Number: _____

Individual Coverage Effective (DD/MM/YYYY):_____

Individual Coverage Expiration (DD/MM/YYYY): _____

Policyholder / Insured Person Information

First Name: _____ Last Name: _____

SSN: _____

Email Address: _____ Cell Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

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Employer Information of Policyholder/Insured Person

Name of Employer: _____

Occupation: _____

Employer's Address

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Work Phone: _____

Claimant Information (if different from Policyholder/Insured Person)

First Name: _____ Last Name: _____

SSN:

Email Address: _____ Cell Number:

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: Country: _____

County: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Relationship to Policyholder/Insured Person:

Employer Information of Claimant

Name of Employer: _____

Occupation: _____

Employer's Address

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Work Phone: _____

Section B: Details of Accident

Date of Accident: _____ Time of Accident/Illness: _____

Describe how the accident occurred: _____

_____

_____

_____

_____

Is this a job-related accident? ☐ Yes ☐ No

If **Yes**, please complete the *Other Insurance* information below in **Section D.**

Are you receiving Workers Compensation benefits? ☐ Yes ☐ No

Where did the Accident/Illness Occur?

Name of Event/Location/Facility: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Name of Activity (if applicable): _____

Name of Sport (if applicable): _____

Did the Accident occur:

While the claimant was supervised? ☐ Yes ☐ No

If **Yes**, Supervisor name: _____

During sponsored activity? ☐ Yes ☐ No

During programmed hours? ☐ Yes ☐ No

While traveling to or from a regularly scheduled activity in a supervised group? ☐ Yes ☐ No

Additional Information

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐Yes ☐No

If **Yes**, please provide details below (Please use supplementary sheet if necessary):

Name / Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date and Time Consumed

Witness Information

Were there witnesses to the accident? ☐ Yes ☐ No

If **Yes**, please provide the following details:

Witness 1

First Name: _____ Last Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Witness 2

First Name: _____ Last Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Supplemental Employement Information Due to Accident/Illness:

Date last worked (DD/MM/YYY): _____

Date returned to work (DD/MM/YYYY): _____

Weekly earnings: _____

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Section C. Nature of Injury

Describe in detail the injuries sustained, indicating the part(s) of the body injured and the type of injury (e.g., fracture, cut, bruise, etc.): _____

_____

_____

Treating Physician for Accident/Illness

Name: _____

Physician Specialty: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Treatment Start Date (DD/MM/YYYY): _____

Treatment End Date (DD/MM/YYYY): _____

Policyholder/Insured or Claimant Primary Physician

Name: _____

Physician Specialty: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Details of Hospitalization (Please attach In-Patient Discharge Summary and Original Final Hospital Bill)

Name of Hospital: _____

Period of Hospitalization

From: (DD/MM/YYYY): _____

To: (DD/MM/YYYY): _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Phone #: _____

Medical Record Number: _____

Section D: Other Insurance Information

Please provide the information below for any other insurance under which the claimant is insured.

Other Insurance 1

Insurance Company Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Policy Number / Account Number: _____

Claim Reference Number: _____

Other Insurance 2

Insurance Company Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Policy Number / Account Number: _____

Claim Reference Number: _____

Section E: Claimant Guardian and/or Legal Representative Details

Must be completed by the claimant or parent/guardian of claimant, if claimant is a minor.

Claimant Guardian Information

First Name: _____ Last Name: _____

Relationship to Claimant: _____

Guardian's SSN: _____

Email Address: _____ Cell Number: _____

Claimant Guardian Address

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Guardian Empoyer: _____

Employer Address

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County _____

Policyholder/Insured Person and Claimant Legal Representation

Do you have legal representation? ☐ Yes ☐ No

If **Yes**, please provide representative details below.

Name of Firm: _____

First Name: _____ Last Name: _____

Title: _____

Email Address: _____ Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Phone #: _____

Section F: Authorization and Assignment of Benefits

By signing the below I hereby certify that the above information is true and correct to the best of my knowledge and belief.

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 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 *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

_____

Signature of Insured or Authorized Representative

_____

Signature of Parent / Legal Guardian of Authorized Representafive of Claimant, if Claimant if a minor)

Date: _____

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning:
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents 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.

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.

Florida
Any person who knowingly and with intent in 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.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.