How To File a Claim

Troop Leader's or Other Activity Representative's Procedures:

1. Complete, including original signature, each section of the claim form to the best of your ability. Be sure to provide all the information required to expedite processing and to avoid delay.*
2. Submit an itemized bill complete with diagnosis, date(s) and procedure code(s).
3. Retain one copy of the completed claim form for your records.
4. Send the original and one copy to the council for validation along with any available bills for covered expenses which have been incurred. **Claims will not be processed without council signature.**

*** NOTE: The address section on the claim form must be the Claimant's home address, not the council or camp property address or the address where the covered event was held.**

Council Procedures:

1. The council receives the completed claim form and reviews for: membership status or purchase of optional insurance, eligibility, presence of a bill and that the activity information provided is sufficient to confirm the claim is for a Girl Scout related accident or illness.
2. The activity information section shown on the claim form must be completed. When marking this section, exercise good judgment (i.e. while at camp a girl falls over a log while walking across the beach; the aquatic section should not be marked as she was not in or on the water. The appropriate section is slips/ falls and other [carpet, log, stairs, etc.]).
3. Council official must sign the form.
4. Councils should not sign blank forms and release them to troop leaders. **Remember, United of Omaha relies on the council to verify that the claim is for a Girl Scout related accident or illness.**
5. Retain one copy of the claim form for Council records. Send the original (with any bills) to:

   United of Omaha Life Insurance Company
   Special Risk Services
   P.O. Box 31156
   Omaha, NE 68131
   Or Email to:
   specialrisk.claims@mutualofomaha.com

Questions on insurance claims should be referred to the P.O. Box number above or call: 1 (800) 524-2324

Girl Scouts of the U.S.A. Claim Form

Mail any additional bills (properly identified by injured person and Council name) to:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
1-800-524-2324

Claimant Information – All Questions Must Be Answered

Claim is made under the following Plan:

- ☐ Plan 1 – Basic Coverage
- ☐ Plan 2 – Participant Accident
- ☐ Plan 3E – Extended Event
- ☐ Plan 3P – Extended Event
- ☐ Plan 3PI – International Extended Event
- ☐ International Inbound

Enrollment Request ID: __126766_____
(Applicable to Optional Coverages only)

Name of claimant | Identification Number | Age | Date of Birth

Claimant's address | Number and Street | City | State | ZIP Code

If claimant is a minor, name of parent or guardian | Phone Number ( ) -

Address of parent or guardian | Number and Street | City | State | ZIP Code

If your organization has selected coverage containing a Nonduplication amount, the benefits will be considered as follows: The Nonduplication amount, as stated in your selected coverage, of medically necessary services and supplies can be paid regardless of other insurance coverage. For expenses over the Nonduplication amount, or if you expect the total to exceed the Nonduplication amount, you must submit to your primary insurance carrier. We require their Explanation of payment even if it is applied to your deductible. If Denied, send a copy of your denial notice. Include itemized bills.

Father, Guardian or Claimant's (if adult) Employer's Name and Address: _____

_____ **Phone No. (** _____ **)** _____ **-** _____

Mother, Guardian or Spouse's Employer's Name and Address: _____

_____ **Phone No. (** _____ **)** _____ **-** _____

Name of all companies providing your insurance coverage or prepaid health plans.

Name of Company	Address	Policy or Certificate No.

If you do not have other coverage, sign and date the following statement.

I, _____ **, on** _____ **, verify there is no other insurance coverage available for these and all expenses related to this claim.**

I hereby certify that all above information is true and complete.

I verify that I have read and understand the fraud statement for my state that accompanied this form.

New York Claimants: 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. (PURSUANT TO 11 NYC RR86)

_____ _____
Signature (Parent/Guardian) **Date**

ATTACH ITEMIZED BILLS WITH A DOCTOR'S DIAGNOSIS

GIRL SCOUT LEADER STATEMENT

Troop Number _____ Level: 0 ☐ Daisy 1 ☐ Brownie 2 ☐ Junior 3 ☐ Cadette 4 ☐ Senior 5 ☐ Adult Member 6 ☐ Nonmember Child 7 ☐ Nonmember Adult 8 ☐ Staff 9 ☐ Seasonal Staff 51 ☐ Ambassador

Name of Council | Council No. | Phone Number ( ) -

Council's address | Number and Street | City | State | ZIP Code

Date and place of accident or sickness	Date and location	Nature and details of injury or sickness

Activity information

Type of activity (check below):

1. ☐ Autos/Vehicles
   - ☐ Driver
   - ☐ Passenger
   - ☐ Pedestrian
2. ☐ Slips/Falls on/at/over/from
   - ☐ Equipment/Furniture
   - ☐ Animals
   - ☐ Other (carpet, log, stairs, etc.)
3. ☐ Using Tools
   - ☐ Saw
   - ☐ Knife
   - ☐ Stove
   - ☐ Kiln
   - ☐ Other
4. ☐ Aquatics (in/on water)
   - ☐ Swimming/Diving
   - ☐ Boating/Canoeing
   - ☐ Water Skiing
5. ☐ Poisonous Plants/Insects (poison ivy/bee stings)
6. ☐ Skating
   - ☐ Roller
   - ☐ Ice
7. ☐ Illness/Sickness
8. ☐ Other Accident

Overnight events

Was this an overnight event? ☐ Yes ☐ No If "Yes," number of nights _____

Name of event:

Indicate dates of attendance from to

Troop validation or authorized activity representative's validation

We hereby certify that the insured person is a currently registered Girl Scout or that the required premium for insurance coverage has been paid for this person and that the claimant was participating in an authorized Girl Scout activity as described above.

Activity Representative's Signature/Troop Leader's Signature | Date

Street Address | City | State | ZIP Code

Did injury occur during course of employment? ☐ Yes ☐ No

Claims covered by the Council's workers' compensation policy should not be submitted to United of Omaha.

COUNCIL USE ONLY

I certify that this injury or sickness occurred as described and that the activity was sponsored and supervised by the Girl Scouts.

Council Official's Signature | Date

Authorization for Release of Information

I authorize the Mutual of Omaha Insurance Company and/or its affiliated companies to disclose my or my children's personal information to Girl Scouts U.S.A. for purposes of claim confirmation.

The personal information may include such items as claim and medical information, including diagnosis, mental and physical condition, prescription drug records, and other related claim information.

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment, my eligibility for benefits or my ability to obtain payment, but may delay the processing of my claim.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha Insurance Company, ATTN: Special Risk Claims, Mutual of Omaha Plaza, Omaha, NE 68175.

I understand that I am entitled to receive a copy of the signed authorization.

_____ _____

Signature **Date**

_____

Relationship to Insured

Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

** **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.

** **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.

** **Arkansas, Louisiana and Rhode Island:** 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.

** **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.

** **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.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an 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.

** **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.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **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.

** **Kentucky:** 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.

** **Maine:** 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.

** **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.

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

** **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 of insurance fraud, as provided in RSA 638:20.

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

** **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 APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **Ohio:** 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.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds 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 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.

** **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **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 include imprisonment, fines and denial of insurance benefits.

** **Texas:** 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.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.