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## NOTIFICATION OF INJURY

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## United States Fire Insurance Company

This Notification of Injury Form is to be used for accident medical claims. **This form and all other correspondence must be submitted within 90 days from the date of accident.**

### Policies With Excess Coverage

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

### Policies With Primary Coverage

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

### Claim Form

This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

### Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital.

### Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

### Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is to be sent.

*If the injured person has primary health insurance has the claim been submitted first to the primary health insurance company?*

Yes  No

*If claim has first been submitted to the primary health insurance company, are copies of EOB's (explanation of benefits) attached?*

Yes  No

*Is part (A) of the claim form completed by the Policyholder official or staff member and signed?*

Yes  No

*Is part (B) of the claim form completed by the injured person and signed?*

Yes  No

*Are the attached medical bills itemized in either a CMS 1500 or UB04 form?*

Yes  No

*Is part (B), item number 3 (social security number) completed?*

Yes  No

**Mailing The Claim**

When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

The Loomis Company  
P.O. Box 14162  
Reading, PA. 19612-4162

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (866) 915-6618.

Documents may also be faxed to the claims office at (610) 370-6767. Please do not fax full medical claims, as often times medical bills are illegible when faxed. For emailing documents, please email [suppacc@loomisco.com](mailto:suppacc@loomisco.com)

**PLEASE NOTE: Claims Must Be Submitted Within 90 Days Of The Date Of Accident.**

**NOTICE**

**Fraud Warning:** Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

<b>PART A – This PART MUST be completed, dated and signed by an official or the Organization.</b>			
1. Name of Organization and Policy Number			
2. Address of Organization (Street)		(City)	(State) (Zip)
3. Name of Injured Person (Insured)		(First)	(Middle) (Last)
4. Date of Accident/Injury Mo      Day      Year /      /	5. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other _____		6. Type of Sport or Activity:
7. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.			
8. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>		9. Name of Supervisor of Activity	10. Was he/she a witness to Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Signature of Organization Official <b>X</b> _____	12. Title of Official	13. Area Code/Telephone No. (   )	14. Date Signed