SC WORKS | BRINGING EMPLOYERS AND JOB SEEKERS TOGETHER

TRIDENT

Trident Workforce Investment Board
Workforce Investment Act

CUSTOMER ACCIDENT INSURANCE POLICY

TO: SC Works Trident Operators and Youth Contractors

ISSUANCE DATE: May 15, 2012

EFFECTIVE DATE: May 15, 2012

SUPERSEDES: March 30, 2011, June 30, 2008 and July 1, 2007

SUBJECT: Customer Accident Insurance Policy

PURPOSE:
The purpose of this policy is to provide information regarding the guidelines for filing participant accident claims.

POLICY:
The State of South Carolina traditionally procures Accidental Injury Insurance for active Workforce Investment Act (WIA) customers while they are participating in the WIA program. This coverage is extended to all participants who are engaged in all WIA activities except wage based work experience and on-the-job training (OJT). Customers engaged in work activities must be covered by Worker's Compensation Insurance.

The accident insurance policy was renewed effective November 1, 2012 and is effective until November 2013 with the premium being paid by and the policy being issued to the SC Department of Employment and Workforce (SCDEW).

PROCEDURES:
The Special Risk Claim form is attached and procedures outlined below.
The following procedures ***must*** be used for reporting accidents:

- In an emergency, get appropriate medical attention immediately.
- In the event that a claim must be filed, notify the WIA Project Officer at 843-529-0400 ex. 211 to report the accident within 24 hours of occurrence.
- The Project Officer will complete section A of the Special Risk Accident and Sickness form, but the signature line must be left blank for the Berkeley Charleston Dorchester Council of Governments Executive Director to sign as the policy holder authorized official.

- **Section B on the form is for the claimant (customer injured) to complete and sign.** Chartis Accident & Health will pick up any cost that the injured person's personal insurance (if any) will not cover. Therefore, in addition to the completed form, Chartis will need an itemized insurance billing form (hospital form #UB92 or #UB04, or doctor's office form #HCFA1500).
- Staff or Provider present during time of accident should complete the Cover memo and send to the WIA Project Officer
- Completed forms will be sent to the SCDEW Local Operations Coordinator to also include:
    1. The completed and signed original of the Special Risk Accident and Sickness Claim Form
    2. Original itemized bills with diagnosis and the corresponding Explanation of Benefits Notice from the primary carriers; The itemized bill ***must*** include:
        a) Patient's name
        b) Patient's complete address
        c) Diagnosis
        d) Date of Service(s)
        e) Description of treatment (chest x-ray, blood test, etc)
        f) Doctor's/Hospital's name, address and telephone number

If the customer has already paid the doctor or hospital, include a paid receipt or a copy of the canceled check.

If the customer has other bills such as x-rays or laboratory charges, the original itemized bills, and corresponding Explanation of Benefits Notice from their primary carrier must be attached.

CUSTOMERS AND STAFF AND/OR CONTRACTOR SHOULD KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE.

The claim form and all required attachments must be submitted to the project officer within ***30 days*** of the date the customer first received medical care. **IF THE CLAIM FORM WITH ALL ATTACHMENTS IS NOT SUBMITTED WITHIN 30 DAYS, THE CUSTOMER WILL BE LIABLE FOR PAYMENT.**

The Project Officer will forward a copy of the Accident Claim Form to the Berkeley Charleston Dorchester Council of Governments to make them aware of the incident.

Ronald E. Mitchum, Executive Director
BCDCOG

7/19/13
Date

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TRIDENT

TRIDENT WORKFORCE INVESTMENT AREA
WIA CUSTOMER INJURY REPORT

COVER MEMO

TO: Project Officer, Berkeley Charleston Dorchester Council of Governments

FROM: _____
Staff or Provider Name Printed

DATE: _____

RE: ACCIDENT INJURY REPORT

WIA Customer Name: _____

Last 4 digits of SSN: _____

Date of Injury: _____

Place of Injury: _____

Type of Injury: _____

How Injury Occurred: _____

_____

Name(s) of those who eye witnessed the injury:_____

Additional Comments:

_____

_____

_____
Printed Name of Person Completing this Cover Memo

_____
Signature of Person Completing this Cover Memo Date

CHARTIS
Accident & Health Claims Department
PO Box 25987
Shawnee Mission, KS 66225

800 551 0824 Telephone
866 893 8574 Facsimile
A&H.Claimssubmissions@chartisinsurance.com

Date

CHARTIS

Dear Policyholder,

Attached is a copy of the Special Risk claim form you requested. Please read the following information and instructions very carefully as all of the information is required for us to begin reviewing your claim.

- Each person filing a claim will need to submit a separate claim form.
- All sections of the claim form must be completed in detail paying special attention to the following:
  - Please ensure that you complete the section on How, When and Where Accident Occurred to include the Date and Time of the accident.
  - Please ensure that the Policyholder signs at the bottom of Section A
  - Please ensure that the claimant (injured party) signs at the bottom of the claim form
- Attach itemized bills provided by the providers/facilities (HCFA 1500 for Providers and UB92/UB04 for facilities) for all medical expenses being claimed which must include the following:
  - Claimant' name
  - Condition being treated (Diagnosis/Diagnosis Codes)
  - Description of services rendered (Standardized Procedure Codes)
  - Dates and Charges for each service provided
  - Provider's Federal Tax Id Number
- If your policy is an Excess policy (meaning you have other primary insurance), we will need the Explanation of Benefits (EOBs) from your primary insurance company confirming what they have paid sent in with the claim form and itemized bills

Once your claims package is received, it will take approximately 10-15 business days to review your claim. Failure to submit all requested documents could result in a delay of the claims process. Please keep in mind that all decisions regarding claims will be made by the Claims Department and will be based on the documentation provided when the claim is filed.

If you have questions/comments, please contact our Customer Service Department at 1-800-551-0824.

Regards,

Customer Service Department
Chartis Accident & Health

National Union Fire Insurance Company
Chartis Accident & Health
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-893-8574 (Facsimile)

PROOF OF LOSS

NAME OF GROUP: South Carolina Department

POLICY NUMBER: SRG9132108

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)	NAME OF SUPERVISOR

☐ MALE ☐ FEMALE	U.S. CITIZEN ☐ Yes ☐ No	DATE OF BIRTH	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	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
INDICATE THE SPORT (IF APPLICABLE)	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ 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 #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT SOCIAL SECURITY NUMBER / DATE OF BIRTH / ☐ Male ☐ Female U. S. Citizen ☐ Yes ☐ No

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.
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
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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each 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, Rhode Island, 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