Table of Contents

INSURANCE

PROPERTY AND LIABILITY INSURANCE

All parishes and diocesan institutions are covered by the diocesan master policy with the Catholic Mutual Group (CMG). CMG invoices each parish and institution annually and premium payments are to be sent directly to CMG. CMG should be notified immediately when there is a change to property covered so that the proper coverage is in force and premiums may be adjusted accordingly.

The Diocese of Nashville participates in the Catholic Umbrella Pool (CUP) II, which consists of a group of Dioceses from across the country who have joined together to share risk. The purpose of the pool is to provide a layer of self-insurance for excess liability coverage.

One of the requirements of CUP II is to participate in a risk management program. This is a comprehensive program in which the diocese and Catholic Mutual participate as follows.

1. CMG will generally conduct safety inspections at locations on an annual basis. These locations may include (but will not be limited to) high schools, selected grade schools, retreat centers, the cathedral, the chancery, cemeteries, charities offices, and identified problem locations, if any;
1. Safety seminars and workshops are strongly recommended and, where possible, will be presented in participating dioceses by the Catholic Mutual Group;
2. All locations not inspected by Catholic Mutual will be required to conduct an annual self-inspection report.
3. Various safety information and technical support will be made available where needed. The office of the diocesan Chief Financial Officer will act as liaison between Catholic Mutual's risk management staff and the parishes and institutions. It is suggested that questions regarding specific coverages, unique local conditions, or premium invoices be referred directly to Catholic Mutual.

VEHICLE INSURANCE

All diocesan-owned and parish/institution-owned vehicles are covered by the diocesan master policy that is brokered by Gallagher. The company providing the insurance coverage as of FY24-25 is Church Mutual Insurance Company (CMIC). CMIC will invoice the diocese which will include the charges in statements that are sent to the parishes. Vehicle changes should be reported immediately to Gallagher and the appropriate contact at the diocese. All claims should be made directly to CMIC by email or by visiting their website at www.churchmutual.com.

Participation in the Catholic Umbrella Pool (CUP) II also requires that the Diocese of Nashville have a written vehicle safety policy to minimize exposure to loss due to vehicular accidents. To that end, every parish and institution of the diocese having a vehicle covered

by the diocesan master policy must adhere to the vehicle safety policy included in **Exhibit (A)**.

It is suggested that any questions concerning worker's compensation insurance be referred directly to Gallagher.

WORKERS COMPENSATION INSURANCE

All employees in the diocese, including priests and religious, are covered by the diocesan master worker's compensation insurance policy brokered by Gallagher. The company providing the insurance coverage as of FY24-25 is Church Mutual Insurance Company (CMIC). CMIC will invoice the diocese which will include the charges in statements that are sent to the parishes.

Worker's compensation insurance provides for payments to employees for any injury which may arise out of and in the course of their employment. Injured employees should inform their doctor and/or hospital that their injuries are compensable under worker's compensation. Injured employees should contact the CMIC claims department immediately after an accident occurs. Upon presentation of a claim, CMIC will make the necessary payments as required by the Worker's Compensation Law.

A sample of an "Incident Investigation Report for Injuries" form is included as **Exhibit (B)**. This report should be filled out for all incidents/injuries and near-miss incidents/injuries.

Included as **Exhibit (C)** is a document provided by CMIC which highlights the resources available as part of this coverage, including steps to file a claim and how to contact our complementary Nurse Triage Hotline.

It is suggested that any questions concerning worker's compensation insurance be referred directly to Gallagher or CMIC.

STUDENT AND VOLUNTEER ACCIDENT INSURANCE

All students and volunteers in the diocese are covered by the diocesan master student and volunteer accident insurance policy brokered by Gallagher. The company providing the insurance coverage as of FY24-25 is Bob McCloskey Insurance (BMI). BMI will invoice the diocese for this particular coverage.

Included as **Exhibit (D)** is the Claim Filing Checklist provided by BMI. The steps highlighted therein should be completed and submitted to BMI to initiate a claim.

It is suggested that any questions concerning student and volunteer accident insurance be referred directly to Gallagher.

CYBER LIABILITY INSURANCE

All locations in the diocese are covered by the diocesan master cyber liability insurance policy brokered by Catholic Mutual Group. The company providing the insurance coverage

as of FY24-25 is Tokio Marine. Tokio Marine will invoice the diocese for this particular coverage.

It is suggested that any questions concerning cyber liability insurance be referred directly to Catholic Mutual Group.

CRIME INSURANCE

All locations in the diocese are covered by the diocesan master crime liability insurance policy brokered by Gallagher. The company providing the insurance coverage as of FY24-25 is Travelers. Travelers will invoice the diocese for this particular coverage.

It is suggested that any questions concerning crime insurance be referred directly to Gallagher. In addition, please notify the diocesan risk management representative immediately if you are aware of any criminal activity.

OTHER COVERAGE

There may be coverage for other events not specified herein. Please contact the diocesan risk manager if you have any specific questions relating to coverage.

FIELD TRIP POLICIES

Field Trip (Statement of Policy)

The Diocese of Nashville and/or School recognizes the importance and value of trips for educational field study and approves of these visits to places of cultural or educational significance to further enrich the lessons of the classroom. This policy permits principals and/or assistants/vice principals to approve of field trips during normal school hours on a single school day. However, it out-of-state field trips, or any field trips to foreign countries are planned, these must have the ultimate approval of the Diocese and/or school board. The following regulations should be taken into consideration when any field trips are being planned. They are as follows:

1. Adequate supervision by qualified adults, including one or more certificated employee of the Diocese and/or school.
2. Waivers by all adults and all parents/guardians of students taking any field trip of all claims against the Diocese and/or the school for injury, accident, illness or death occurring during, or by reason of the field trip.
3. Proper insurance for students, personnel, and equipment.
4. Inclusion of a proper first aid kit and fire extinguisher.
5. Permission in written form from each student's parent or legal guardian.

Finally, to insure the desired outcome of such field trips, teachers should prepare the students for the place that is to be visited and the things that are to be seen. A thorough discussion should be held regarding the purpose or purposes as well as, the goal or goals of the trip. Additionally, an advance visit should be made to the site of the field trip by the teacher so that any and all unforeseen circumstances, situations, and/or events could be properly planned for; so that any difficulties would be minimized.

Field Trip Written Consent Form

The written consent of parents and/or legal guardians must be outlined for every student participating in a field trip. Permission slips must inform parents and/or legal guardians of the following (sample form is attached):

1. Name, location, and date(s) of the event.
2. Mode of transportation to be used.
3. Name of Diocesan/school employee in charge of the field trip.
4. Parents' responsibility.

It should also be noted that no student will be allowed to participate unless a signed permission slip for the specific event is on file with the Diocese or school, this permission slip must be submitted prior to the field trip, and it must be signed by the parent and/or legal guardian.

Parent Permission Form for Field Trip Participation

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a school-sponsored activity requiring transportation to a location away from the school building. This activity will take place under the guidance and supervision of employees from _____ School. A brief description of the activity follows:

Curriculum Goal:

Destination:

Designated Supervisor of activity:

Date and time of departure:

Date and anticipated time of return:

Method of transportation:

Student cost:

If you would like your child to participate in this event, please complete, sign, and return the following statement of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named student.

I hereby consent to participation by my child, _____, in the event described above. I understand that this event will take place away from the school grounds and that my child will be under the supervision of the designated school employee on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

_____

Parents Name/Signature

_____

Address

_____

Emergency Phone

Field Trip Transportation Policy

Bus transportation is the most desirable method to be utilized for any field trip and whenever possible, this mode of transportation should be provided. The use of private passenger vehicles is discouraged and should be avoided if at all possible.

If a private passenger vehicle must be used, please adhere to the requirements as described in Exhibit (A).

A signed DRIVER APPLICATION on each vehicle used must be submitted to the principal, DRE or project coordinator prior to the field trip. Please see Exhibit (A) for details.

Each driver and/or chaperon should be given a copy of the approved itinerary including the route(s) to be followed and a summary of his/her responsibilities. For field trips other than interscholastic athletic field trips, the following supervision requirement should be maintained, for every (10) students, there should be (1) adult.

EXHIBIT A – VEHICLE SAFETY POLICY

I. DRIVERS

A. EMPLOYEE OPERATORS

1. Drivers must be 21 years of age or older. Exceptions may be granted upon diocesan approval.
2. A driver must have a valid, non-probationary driver's license and no physical disability that would impair his/her ability to drive the vehicle safely.
3. Vehicles owned by the diocese cannot be used for personal use. If a vehicle is taken home it must only be operated by the employee driver who is assigned to operate the vehicle
4. The Driver Application (Appendix A) must be completed by all potential employees who are required by their job descriptions to drive a vehicle with passengers/students or have responsibilities to operate a motor vehicle and will complete the Defensive Driving Curriculum & Motor Vehicle Report annually.
5. An applicant must include a copy of the Motor Vehicle Record (MVR) from each state where he/she has ever had a valid driver's license.
6. Any employed driver who causes an accident in a diocesan owned vehicle or who is cited for two moving violations within a 12 month period will be required to attend a defensive driving course and the accident will be reviewed by the Risk Manager and the employee's supervisor.

B. VOLUNTEER OPERATORS

1. Operators must be 21 years of age or older. Exceptions may be granted upon diocesan approval.
2. Drivers must have a valid, non-probationary driver's license and non-physical disability that would impair his/her ability to drive the vehicle safely.
3. Any volunteer who drives on a regular basis for diocesan/parish business will have an MVR check completed.
4. Drivers must complete the Volunteer Driver Application (Appendix B).
5. Potential drivers may not be utilized if they answered "YES" to part B of the Volunteer Driver Application.

C. ALL OPERATORS

1. Operators must possess a current valid driver's license for the type of vehicle he/she will be operating.
2. No operator will be hired or be allowed to provide volunteer transportation on behalf of any Diocesan entity who has had any of the following citations or convictions in the past three years:
    a. Operating a vehicle during a period of license suspension, revocation, or forfeiture
    b. Driving under the influence of alcohol or drugs
    c. Hit and run accident
    d. Failure to report an accident
    e. Negligent homicide arising out of the use of a motor vehicle
    f. Using a motor vehicle for the commission of a felony
    g. Operating a motor vehicle without the owner's authority
    h. Permitting an unlicensed person to drive
    i. Reckless driving
    j. A combined total of three or more accidents and/or moving violations
3. It is the responsibility of the operator to ensure that passengers adhere to the current State of Tennessee traffic and vehicle regulations.
4. Alcohol, illegal drugs, and firearms are not permitted in vehicles or to be used by vehicle operators.

II. USE OF PRIVATE VEHICLES

1. All privately owned vehicles used on behalf of the diocese must be insured. They must have a valid and current registration and license plates and provide proof of insurance.
2. The vehicle must be in safe operating condition.
3. The private automobile insurance company of the owner of the vehicle will be the primary insurance carrier.
4. The minimum liability limit for privately owned vehicles is: $100,000/$300,000.
5. A Private Vehicle Use Application (Appendix C) must be completed for each vehicle.

III. DIOCESAN VEHICLE MAINTENANCE

Each institution will implement a quarterly vehicle maintenance and inspection program in addition to the manufacturers' operation and maintenance recommendations. Vehicles, especially buses, must be physically inspected to insure safe operation.

IV. DIOCESAN VEHICLE SAFETY

1. All diocesan-owned passenger transportation vehicles must be equipped with:
    a. First-aid kit
    b. fire extinguisher
    c. road safety kit
    d. Bodily fluid disposal kit.
2. Cell phones and other electronic devices are not permitted to be used while operating a motor vehicle.

V. ACCIDENT REPORTING

If an accident occurs:

1. Obtain medical assistance, if needed, at the scene as soon as possible.
2. Contact local police, sheriff or highway patrol authorities as required.
3. Exchange driver, vehicle, and insurance information.
4. Report the accident/moving violation to the diocesan auto insurance representative
5. Report as required by the State of Tennessee Department of Homeland Security.

VI. RECORD KEEPING

1. Records pertaining to driver selection and training should be kept on file for a period of three years following termination of their driving privileges.
2. Vehicle maintenance logs and vehicle inspections, (Appendices D, E, & F) must be maintained for the duration of ownership of such vehicle.
3. All diocesan owned vehicles must carry, at all times, a current automobile insurance identification card.
4. Retention of Forms:

    Driver Application - retain for a minimum of 3 years

    Volunteer Driver Application - retain for a minimum of 3 years

    Private Vehicle Use Application - retain for a minimum of 3 years

Vehicle Maintenance & Service Log - retain for the duration of ownership

Daily Bus Inspection - retain for the duration of ownership

Annual Vehicle Exterior Inspection - retain for the duration of ownership

Vehicle Accident Report - retain for 7 years from date of accident

EXHIBIT B – INCIDENT INVESTIGATION REPORT FOR INJURIES

INCIDENT INVESTIGATION REPORT FOR INJURIES

Complete this report for all incidents/injuries. (Also, complete this report for near-miss incidents/injuries). This report is for information only. All claims should be reported immediately to Brian Bednarz (615)783-0777 or by email brian.bednarz@dioceseofnashville.com.

Please read each question carefully and answer **all** questions as completely as you can.

Name of Injured Person: _____ Phone: _____

Complete address: _____

Names of Witnesses and their complete addresses and phone numbers:

_____

_____

Describe the Incident: (State what the individual was doing and all circumstances leading up to the incident. Try to reconstruct the chain of events leading up to the incident/injury. Be specific.)

Who was involved? _____

What took place? _____

_____

When did it occur? Date _____ Hour of incident _____ AM PM

Where did it happen? _____

Why did it happen? _____

_____

How did it happen? _____

_____

_____

Corrective Action:

1. In your opinion, was this incident preventable? Yes _____ No _____
2. If yes, state why. _____
3. What action have you taken or do you propose taking to prevent a similar incident from taking place?

_____

Training:

Have you provided any training to prevent this incident? If not, describe training to be conducted.

_____

Incident Investigation conducted by:_____

_____ _____

Signature of individual in charge Date report prepared

EXHIBIT C – WORKERS COMP BOOKLET

PROTECTING THE GREATER GOOD | Church Mutual INSURANCE

Church Mutual Service Team

Tosha Parish	Territory Manager	tparish@churchmutual.com	+1(715)804-7136
Myles McTavish	Associate Territory Manager	mmctavish@churchmutual.com	+1(715)804-7064
Brittney Zinkowich	Broker Account Manager	bzinkowich@churchmutual.com	+1(715)539-4222
Daniel Hanson	Broker Claims Service Coordinator	dhanson@churchmutual.com	+1(715)539-5822
Peter Denando	Risk Control Service Coordinator	pdenando@churchmutual.com	+1(630)947-5527

Meeting Agenda

Introductions:	- Introductions from Church Mutual, RPS, Gallagher, and Diocese Nashville
Services Overview:	- Review of the Church Mutual services available to Diocese of Nashville
Risk Control:	- Review Loss Data – High Level. - Discuss next steps for Risk Control to target loss drivers. - Church Mutual Safety Resources and Trusted Partners.
Claims:	- 24/7 Nurse triage (Medcor) - Special Handling. - Claim Review Meetings.
Questions?	- Open Discussion.

Eligible Services:

- Use of Risk Control's Consulting and Research Center.
- Access to churchmutual.com for information such as:
  - Instructions on how to file a claim.
  - Safety resources, Risk Control services and tools.
    - Webinars – Videos
- 24/7 Nurse triage services for workers' compensation clients through Medcor.
- Concentra - Telemedicine for workers' compensation injuries.
- Designated Broker Account Manager to coordinate the consulting, analysis, and service. for your account.
  - Onboarding meeting.
  - Pre-renewal stewardship report.
  - Annual service review and planning meeting.
- Automated RMIS loss reports.
- Three virtual claim review meetings per year.
- Limited special claim handling tailored to your unique needs.
- One license for the Risk Management Information System with virtual training.
- Development of a customized risk control service plan including up to four coverage related risk control visits.

Claims

- How to file a claim.
  - 24/7 Nurse triage (Medcor) - 1-844-322-1662
  - Email - claimsintake@churchmutual.com
  - Phone - (800) 554-2642
  - Fax - (715) 539-4651
  - Online - Report a Claim (churchmutual.com)

Risk Control

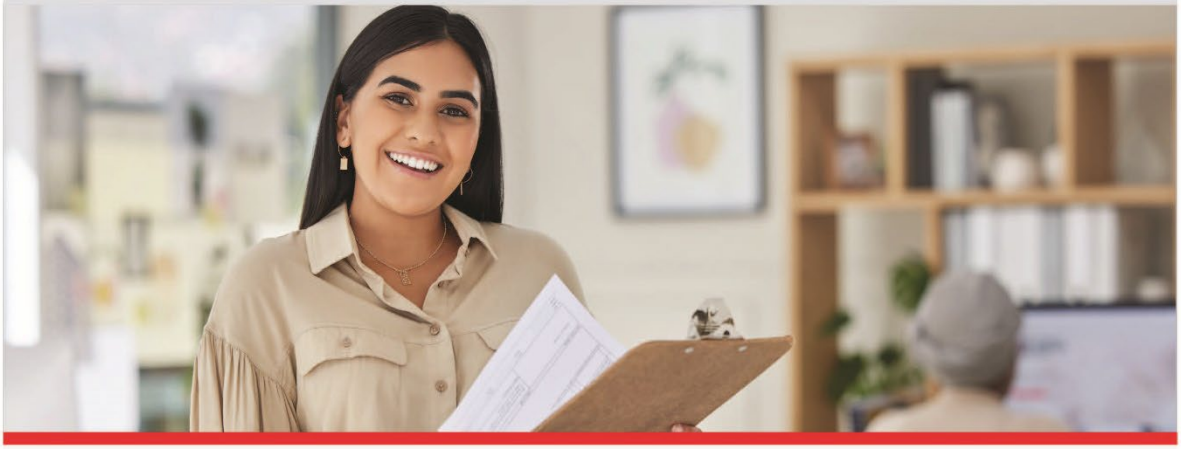
- Safety Resources & Featured Programs - Safety Resources - Risk Control | Church Mutual
- Risk Control Field Specialists.

RISK CONTROL SERVICES

PROMOTING SAFETY FOR PEOPLE AND PROPERTY

PROTECTING THE GREATER GOOD®

Church Mutual INSURANCE



Protecting those you serve, along with your employees, visitors and property is a vital responsibility. Church Mutual Insurance Company, S.I. (a stock insurer)[1] is focused on sharing that responsibility with you, knowing an effective risk control program is the best way to help prevent risk-related losses.

Church Mutual® risk control specialists will help you evaluate every aspect of your organization to isolate potential threats to personal safety and property, including risks you may have never considered before. Knowledgeable specialists offer expertise in identifying exposures related to:

- **Employee safety.**
- **Liability risks.**
- **Property protection.**
- **Fire prevention.**
- **Building valuation.**
- **Vehicle fleet practices.**

A collaborative approach ensures your unique needs can be addressed. With expert recommendations and effective resources, your organization can more safely serve the greater good.

On-site consulting

Risk control specialists will provide expert suggestions on potential safety improvements. We also collaborate with a network of vendors for specialized services to provide comprehensive support. Consulting services include:

- Thorough, in-person analysis of your facility.
- Identification of hazards to people and property.
- Feedback on your policies and procedures.
- Safety and emerging risk presentations.
- Assistance planning and implementing safety programs.
- Interviews with key people to discuss your concerns and review safety enhancement recommendations.

Risk Control visits can be requested by emailing RiskConsulting@churchmutual.com.

Safety resources

Knowing effective risk control measures are the best way to help prevent risk-related losses, we are focused on providing you with no-cost services, resources and information. We offer items like swim bands, allergy bands and safety self-assessments to name a few.

We also partner with leading experts to offer their services at reduced or no cost to our customers. More information can be found at churchmutual.com/partnerservices.

Visit churchmutual.com/safety to explore an extensive line of safety and risk management materials and more!

[1]Church Mutual is a stock insurer whose policyholders are members of the parent mutual holding company formed on 1/1/2020. S.I. = a stock insurer.

Safety committee consultation

A safety committee brings together the right people to drive a proactive safety culture. Whether you already have a safety committee or would like to put one in place, we can:

- Attend and participate in meetings.
- Identify improvement opportunities and provide best-practice recommendations.
- Provide safety tools, such as checklists and presentations.

Replacement cost valuations

Establishing replacement cost values helps you select the right level of building coverage. Our specialists or vendor partners will collect building characteristics information that will assist our Property Valuation Team to determine the appropriate replacement cost valuation. In addition, they work with you, so you have the information you need to help ensure you are covered in case of a loss.

Loss analysis

Identifying claims patterns can help break the cycle of recurring losses. Risk control specialists will examine the type, frequency and severity of your claims and discuss specific loss control services to help you make long-term improvements.

Risk Control Central

If you have a safety or risk management-related question, ask Risk Control Central.

Work with knowledgeable and experienced agents dedicated to helping you find solutions. Your questions will be carefully researched based on your unique needs.

Contact Risk Control Central by email at riskconsulting@churchmutual.com or call 800-554-2642, Ext. 5213.

Up-to-date information

We frequently offer articles, tips and more on topics that matter to you.

Visit blog.churchmutual.com to explore information on pressing issues facing your organization.

Protecting those who serve others

Church Mutual makes it our mission to help you protect yours. That's why no one is better suited to serve your insurance needs as we focus on:

- Houses of worship of all denominations.
- Nonprofit and human services organizations.
- Public and private schools, universities and colleges.
- Camps, sports and outdoor recreation.

Protect your organization today.

Contact your Church Mutual representative to learn more.

800-554-2642 | churchmutual.com/riskcontrol

PROTECTING THE GREATER GOOD®

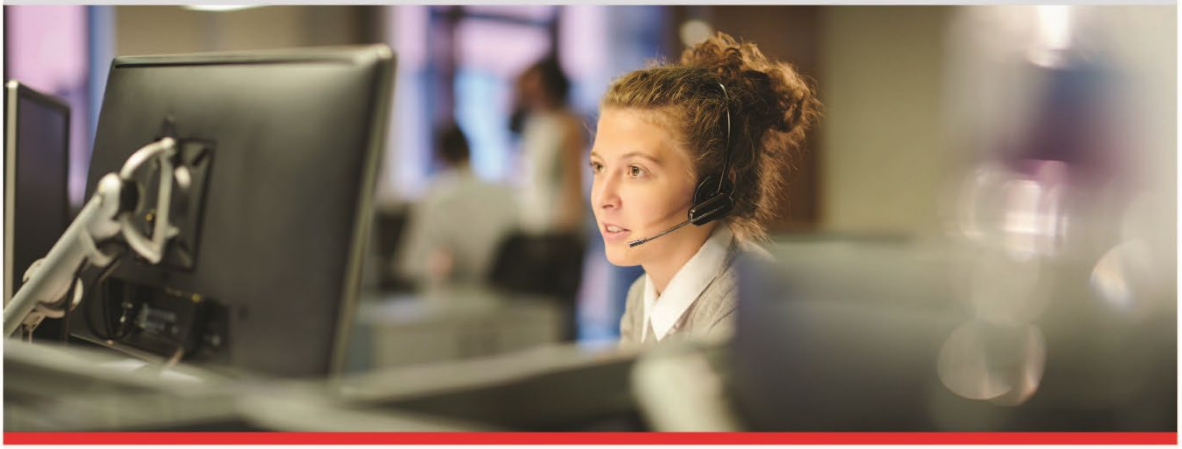
Church Mutual INSURANCE

RISK CONTROL SERVICES

RISK CONTROL CENTRAL
WE'RE HERE FOR YOU

PROTECTING THE GREATER GOOD®

Church Mutual INSURANCE



Risk management is not about luck. It takes effort, and a team of people to make it happen.

Risk Control Central at Church Mutual Insurance Company, S.I. (a stock insurer)[1] is here to help you protect your people, property and organization. We will carefully research your questions and offer solutions to meet the unique needs of your organization, as well as assist you in achieving your safety and risk management-related goals.

Risk Control Central service agents can serve you in many different ways. We can help explore risk management topics relating to your property, liability and workers' compensation concerns. Some common services include the following:

- Discuss armed intruder preparedness planning and security resources.
- Strengthen policies to help reduce the risk of sexual abuse.
- Review steps you can take to ensure your organization is prepared for emergencies.
- Provide advice regarding building maintenance and upkeep.
- Answer questions regarding risk management initiatives, such as the CM Sensor® program.

Help is just a call or click away.

Our consultants are available by phone or email to discuss your questions and concerns.

Contact **Risk Control Central** at:

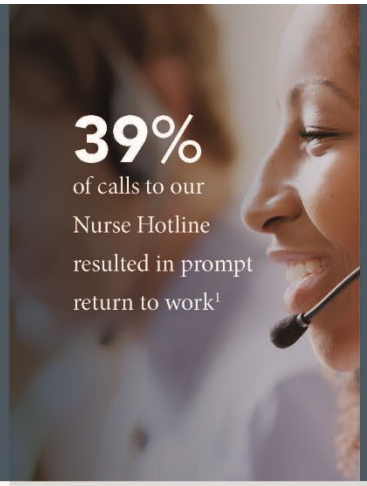
(800) 554-2642 Ext. 5213
RiskConsulting@churchmutual.com
churchmutual.com/rcc

NAIC # 18767; CA Company ID # 2867-0

[1]Church Mutual® is a stock insurer whose policyholders are members of the parent mutual holding company formed on 1/1/2020. S.I. = a stock insurer. CM0049 (11-2023)

Call first. Get advice.

If a life-threatening injury occurs to one of your employees, call 911 immediately. For other injuries, get fast and free decision support at the time of injury by calling the Church Mutual Insurance Company, S.I. (a stock insurer)[1] 24/7 Nurse Hotline. The Nurse Hotline, powered by Medcor, benefits both employees and employers by providing immediate, professional care and helps you mange workers' compensation costs.



39% of calls to our Nurse Hotline resulted in prompt return to work[1]

The right treatment, right away

Getting medical treatment questions answered quickly, at no additional cost to your insurance plan or premium, can help reduce the costs of injuries and future premiums. It also helps employees recover and return to work as soon as safely possible. Employees and supervisors can call specially-trained Medcor Registered Nurses (RNs) who assess the injury and determine the best course of action. Our free Nurse Hotline guides callers to the most appropriate medical treatment based on the severity of the injury — from on-site first aid, to an immediate referral for specialized treatment.

15 minutes is the average time spent on the phone with a Medcor RN. It's faster than a trip to the emergency room or doctor — and it's free.

POWERED BY MEDCOR

Medcor is an important partner of Church Mutual® and one of America's leading providers of injury triage services that can help reduce your loss experience modification and future workers' compensation costs. Medcor's registered nurses are specially trained to respond to workplace injuries and are supervised by a medical director physician who is board certified in emergency medicine. Medcor is accredited by URAC, the preeminent, independent nonprofit health care standards organization.

20% increase in use of in-network providers[2]

How Church Mutual's Nurse Hotline works

STEP 1: Call the 24/7 Nurse Hotline at (844) 322-4662 when a non-life threatening injury occurs.

STEP 2: Nurse makes a recommendation for treatment.

STEP 3: Management receives an update. Employee receives a follow up.

STEP 4: Incident is documented. The claim process is automatically started.

13% reduction in emergency room visits[2]

TALK TO A CHURCH MUTUAL REPRESENTATIVE ABOUT HOW THE NURSE HOTLINE CAN BENEFIT YOU. LEARN MORE AT **churchmutual.com/nursehotline**

[1]Church Mutual is a stock insurer whose policyholders are members of the parent mutual holding company formed on 1/1/2020. S.I. = a stock insurer.

Nurse Hotline – Benefiting you and your employees

Church Mutual INSURANCE

FREE SERVICE

Our Nurse Hotline is a free service for Church Mutual customers. This added benefit provides customers with more control over their employee injury incidents and the workers' compensation process.

EASY TO USE

When a non-life threatening injury occurs, the employee should call our 24/7 Nurse Hotline immediately. The employee's supervisor is welcome to participate in the call. A specially trained RN will assess the injury and determine the best treatment — quickly, efficiently and compassionately.

PROFESSIONAL SERVICE

Church Mutual's Nurse Hotline is staffed by RNs specially trained in workplace injury evaluation and treatment. All operations are supervised by a full-time physician who is board certified in emergency and internal medicine. Translators are available to join the call if necessary.

QUICK RESPONSE

The faster injuries are assessed and treated, the better the outcomes for the employee and the company. Our Nurse Hotline gives the employee and employer guidance within minutes.

ACCELERATED CLAIMS REPORTING

A call to the Nurse Hotline starts the claims reporting process. All information is sent directly to Church Mutual, helping employers save time and control workers' compensation costs. There is no increase in premium for using the Nurse Hotline.

WIN-WIN FOR EVERYBODY

Employers benefit by reducing unnecessary claim costs, shortening reporting lag time, reducing litigation and improving productivity. Employees benefit from immediate medical attention and better medical outcomes.

10% reduction in prescription costs[2]

Nurse Hotline is a must for employers trying to control their workers' comp claims, providing immediate, professional medical care if there is an incident at work — it's simple to implement and use.

— **CHRISTOPHER J. RASMUSSEN, CIC, CWCA**
Ansay & Associates

[1] *July 2016 Medcor Triage Call Outcome and Performance Report for Church Mutual Insurance Company, S.I.*

[2] *July 2016 Church Mutual Insurance Company, S.I. claims review*

S.I. = a stock insurer.

Put our longstanding reputation to work for you

Church Mutual Insurance Company, S.I. is a leading commercial property and liability insurance company serving religious institutions of all denominations, public and private K-12 schools, colleges and universities, senior living communities, camps and conference centers, and nonprofit and human services organizations throughout the United States. We offer commercial property and liability insurance including multi-peril, workers' compensation and commercial auto insurance.

Church Mutual was founded in 1897 and has enjoyed steady, stable growth for more than a century by providing our policyholders with much more than an insurance policy. More than 1,000 employees strive each day to help you prevent losses and to resolve claims as efficiently as possible so that you can return to your valuable work as quickly as possible. We call it, "Protecting the Greater Good®."

It's a philosophy that has helped us achieve:

- **An A (Excellent) Rating from A.M. Best Company**
- **The prestigious Ward's 50 Top Performing Property and Casualty Insurers award**
- **A Top 10 ranking in the Benchmark Portal Top 100 Call Centers**

3000 Schuster Lane | P.O. Box 357 | Merrill, WI 54452-0357

(800) 554-2642 | riskconsulting@churchmutual.com | **www.churchmutual.com**

PROTECTING THE GREATER GOOD® | Church Mutual INSURANCE

PROTECTING THE GREATER GOOD®

Church Mutual INSURANCE

Hurt at work?

Call (844) 322-4662 – Option 1

CHURCH MUTUAL NURSE HOTLINE

Available for non-life-threatening injuries, 24 hours a day, 7 days a week

If an injury is serious or life-threatening, call 911 immediately.

Here's how it works:

1 Make the call *at the time of the injury*

- Immediately report the injury to your manager and he or she will make the call.
- If your manager is not available, then you make the call.
- The nurse manager will retrieve pertinent facts about the injury.

2 The nurse recommendation

- The nurse will provide guidance on injury treatment, either through first aid, the emergency room or a medical clinic.
- A summary of the call, including treatment instructions, will be provided along with the opportunity to ask questions or express concerns.

3 Debrief with manager, if present

- The nurse will summarize the call, the treatment recommendation and the level of urgency.

4 Timely record distribution

- If an outside referral is made, information will be transferred to the medical provider.
- The nurse will submit call information to Church Mutual Insurance Company, S.I. (a stock insurer)[1], which will establish a formal claim.

For more materials you can share with your employees, visit ***www.churchmutual.com/nurseline***

Church Mutual Nurse hotline powered by Medcor®

[1]Church Mutual® is a stock insurer whose policyholders are members of the parent mutual holding company formed on 1/1/2020. S.I. = a stock insurer.

NAIC #18767; CA Company ID #2867-0

CM0083 (05-2020)

EXHIBIT D – BMI CLAIMS PACKET

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
Email: BMI@bobmccloskey.com
www.bobmccloskey.com

Got You Covered

Student Accident Insurance Claim Filing Checklist

PLEASE NOTE – THIS POLICY IS SECONDARY TO PARENTAL/GUARDIAN MEDICAL/DENTAL INSURANCE. THERE ARE SPECIFIC REQUIREMENTS AND SPECIFIC DOCUMENTS NEEDED IN ORDER FOR A CLAIM TO BE PROCESSED AND PAID UNDER THIS POLICY. PLEASE REVIEW THE CLAIMS PACKET IN ITS ENTIRETY.

☐ School – Complete Part 1A of the BMI Benefits Accident/Injury Claim Form.

☐ Parent/Guardian – Complete Part 1B and Parent/Guardian Information Sections of the Accident Claim Form

i. If student/claimant has NO medical/dental coverage, please indicate under Part 1B of the Claim form and complete the Statement of No Other Insurance Document which is included in this packet. ONLY Complete statement of no other insurance if you have no other insurance.
ii. **Please notify all health care providers that you have secondary coverage for the accident/injury.** You should provide them with a copy of the accident claim form and instruct the provider to bill BMI Benefits directly after primary insurance has processed the claim. It is still your responsibility to file the accident claim form directly with BMI Benefits.

☐ Submit completed and signed accident claim form to BMI Benefits, LLC. Please retain a copy for your records.

BMI Benefits, LLC.
PO Box 511
Matawan, NJ 07747
Fax: 732.583.9610
Email: BMI@bobmccloskey.com

☐ See Claim Filing Instructions page for additional information. You will have medical claims/bills to submit to BMI for payment. We recommend NOT paying any bills upfront, but to allow BMI to process the medical claim/bill and we will pay the medical provider directly. BMI will NOT be able to process and pay claims based on balance due statements. The insurance requires itemized bills and primary insurance Explanation of Benefit (EOBs), if applicable, to be submitted for any covered claim to be processed and paid. **We recommend that you contact the medical providers and provide the BMI information as the secondary insurance so the provider can bill BMI directly with the required insurance documents.** If you paid a bill out of pocket, we would need the receipt or statement of account showing payment, **along with the itemized bill and primary EOBs.** See the enclosed materials for additional information.

Enclosed Documents

- Provider Letter with Insurance Information Card
- Statement of No Other Insurance
- Claim Instructions
- Claim Frequently Asked Questions (FAQ)
- Sample Itemized Bills

Student Accident Claim Form

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Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
www.bobmccloskey.com

Got You Covered

Please complete this form in its entirety and submit to BMI Benefits within 90 days from the date of accident. Please retain a copy for your records. **Please contact the medical/dental providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly.** You should provide them with a copy of this form. You may also obtain from the medical/dental providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office), **UB-04** Forms (hospitals), and **ADA Dental Claim Forms** (dentist) **not balance due statements.** Please reference the attached claims instruction document for additional information.

PART 1A - POLICYHOLDER

School/Organization/Policyholder Name	Policy#
Diocese of Nashville	SRG 9156629

School/Organization/Policyholder Mailing Address (Street, City, State, Zip)

Student's Name			Date of Birth	Male ○ Female ○
Date of Injury	Time	Name of Activity or Sport Type	Body Part Injured	○ Left Body Part ○ Right Body Part

At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder? ○ YES ○ NO

Sport/Activity Situation: ○ Game ○ Practice ○ Conditioning ○ Travel ○ PE ○ Recess ○ Classroom ○ Cafeteria ○ Club ○ Bus

How did Injury occur?

Name of School Official:	Title of School Official:
Signature of Supervisor/Official	Date

NOTE: Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed

PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION

Student's Social Security Number (SSN Must be provided as required by the Center for Medicare Services)

Student's Home Address (Street, City, State, Zip)

Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability

Policy? **YES** ○ **NO** ○ If Yes, Name of Ins. Carrier: _____ Policy #: _____

Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? **YES** ☐ **NO** ☐

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name		Parent/Guardian Name	
Phone	E-Mail	Phone	E-Mail
Is the Parent/Guardian Employed?	YES ○ NO ○	Is the Parent/Guardian Employed?	YES ○ NO ○

Medical Information Authorization: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organizatio furnish at the request of BMI Benefits, LLC. or the underwriting companies with which it works, information which you may possess inclu findings and treatments rendered and copies of all hospital and medical records for professional services and hospital care rendered on behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communication between us as privileges are hereby expressly and voluntarily waived. A photostat of this authorization shall be considered as valid and as the original. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submi
Important Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents 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 appli insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information conce 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 t dollars and the stated value of the claim for each such violation. (Fraud language varies by state, for additional state specific fraud warni language, please see below.)

Claimant or Authorized Person's Signature	Date

(Edition 4.2021)

IMPORTANT NOTICE

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 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.
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.

(Edition 4.2021)

Student Accident Insurance

Provider Letter & Insurance Information Card

To: Medical Provider

From: BMI Benefits, LLC.

Subject: Excess Student Accident Insurance

To Whom It May Concern:

The School or School District carries an excess student accident insurance policy which insures students when medical claims are incurred as the result of a covered accident or injury.

The insurance policy is through Bob McCloskey Insurance and BMI Benefits, LLC. You should not collect any payment from the student at the time of service. Any primary insurance deductible amount/copay amount will be eligible to be submitted under the policy with BMI, and will be processed according to the policy terms, conditions, benefits and limitations.

The itemized bills (HCFA 1500, UB04 or ADA Dental) along with the primary E.O.B.(if there is primary insurance) should be submitted directly to BMI. At any time, you can contact BMI Benefits for student eligibility, benefits, or status questions at 800.445.3126.

Sincerely,

BMI Benefits
P.O. Box 511 | Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
BMI@bobmccloskey.com
www.bobmccloskey.com

INSURANCE INFORMATION CARD

Policy #: Student Initials & D.O.B. **Group #:** School Name

CLAIM FILING INSTRUCTIONS

Coverage under this policy is Excess of all other insurance and claims must first be submitted to any other insurance. Initial medical treatment must be incurred within 90 days from the date of the accident. Claims must be submitted to BMI Benefits LLC within 90 days after the date of treatment. Mail, Fax or E-Mail all medical bills and primary insurance statements showing payment or rejection, please include the name of the insured and the name of the school that the student attended to:

BMI Benefits, LLC
P O Box 511, Matawan, NJ 07747
Phone: 800-445-3126
Fax: 732-583-.9610
E-Mail: BMI@bobmccloskey.com

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Got You Covered

Statement of No Other Insurance

Please complete this form in its entirety and submit to BMI Benefits, LLC along with the completed accident claim form ONLY IF you have no other insurance

Insured Name: _____

School/Policyholder Name: _____

Date of Accident: _____

I declare that I was not covered by any other insurance policy, through myself, my parents, or my guardian, for the accident dated above. Should any insurance become effective during my treatment I will notify BMI Benefits and forward all eligible bills to the other insurance carrier. I understand the coverage through BMI Benefits is excess to all other insurance and will pay after all collectible insurance has adjudicate my claims. I understand that if any of these statements are false it could deem my claim ineligible.

_____ _____
(Insured Name or Parent Name if insured is a minor) (Date)

_____ _____
(Insured Signature or Parent Signature if insured is a minor) (Date)

Fraud Warning:
Any person who knowingly and/or with intent to injury, defraud or deceive an insurance company or other person, files a statement of claim containing false, incomplete or misleading information may be guilt of insurance fraud and subject to criminal and substantial civil penalties.

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Got You Covered

Student Accident Insurance Claim Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Part 1A must be completed and signed by the school/policyholder. All other sections must be completed by the parent/guardian. If you are employed, but do not have insurance, please state "NO INSURANCE" and complete the enclosed form – 'Statement of No Other Insurance'. Otherwise, our office may submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

2. **Please contact all medical providers where treatment was received and instruct them that you have secondary insurance. If you give the medical/dental provider a copy of the BMI Accident Claim Form and the Provider Letter, they should bill BMI directly after they bill your primary health insurance. You may also obtain and attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills, known as HCFA 1500s (physician billing form), UB-04s (hospital billing form) and ADA Dental Claim Form (dentist billing form) The itemized medical bills should show the ICD-10 and CPT codes for the services provided, as well as other necessary information for insurance processing. Balance due statements are NOT itemized bills and cannot be processed and paid by BMI Benefits. The insurance policy is an excess insurance, which means benefits are provided after any other valid and collectible insurance has processed the medical claims.**

3. In regard to claims for a dental injury, the policy will cover accidental injury to sound, natural teeth. The claim must be submitted to **both** the dental insurance and the medical insurance if available. In regards to reimbursement for prescription expenses, we will need a copy of the itemized prescription bill. Cash register receipts only will not suffice.

4. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment along with the itemized bills and primary EOBs. HSAs and FSAs are reimbursable, however HRAs are not reimbursable.

5. Submit the completed claim form, itemized bills and primary insurance Explanation of Benefits to BMI Benefits, LLC. Claims can be submitted via mail, fax, or e-mail.

FAX	MAIL	E-MAIL
732-583-9610	**BMI Benefits, LLC** **PO Box 511** **Matawan, NJ 07747**	**BMI@bobmccloskey.com**

6. You may contact BMI Benefits, LLC at 800.445.3126 or BMI@bobmccloskey.com to discuss your claim. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim. All submitted claims are subject to the policy terms, conditions and benefits as outlined in the coverage selected by the Policyholder.

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P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
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Got You Covered

Student Accident Insurance Frequently Asked Questions

Why is my child's school providing student accident insurance?
Many health insurance plans have high deductibles and plan limits that leave parents with high bills resulting from an unexpected accident. This excess policy, provided by the school, protects students and families from the costs associated with school-time and/or sports related accidents depending on your school's chosen policy coverage.

Who is BMI Benefits?
BMI Benefits, LLC. is the claims administrator on behalf of the insurance carrier.

Does primary insurance always have to pay first?
Yes. Medical claims must always be submitted initially to your primary insurance policy. Any remaining balance of expenses not covered by your primary will be submitted to the excess policy. The policy will cover the remaining balance of eligible expenses up to the plan maximum.

Does the accident insurance policy pay for out-of-pocket expenses such as co-pays and deductibles?
Yes. These charges can be submitted to the accident insurance policy to provide reimbursement.

What documents are needed to process a claim?
If your student is involved in a school-related accident, the following documents are needed to properly process a claim:

- **Fully completed BMI Benefits Accident Claim Form**
- **Itemized Bill – <u>in the form of a HCFA, UB04 or ADA Dental Claim</u>**. These can be obtained through the medical/dental provider. **DO NOT SEND** cash receipts, balance due, balance forward, or past due statements for claims processing or payment. An itemized bill (HCFA or UB04) contains the following information:
  - Provider's Name, Provider's Address, Tax ID Number
  - Date(s) of Service, Type of Service(s) Rendered including CPT and ICD-9 Codes
  - The Fee for Each Procedure
- **Primary Insurance Explanation of Benefits (EOB)** – you should receive a copy of this from your primary insurance carrier. If your health insurance coverage is a state or federal government funded plan such as a Medicaid, Medicare, or Military insurance such as Tri-Care, the primary EOB is not required.

Where do I send all of these documents?
Please send all claim forms, itemized bills, primary EOBs, other insurance information and claims correspondence to BMI Benefits, LLC. **It will be easier to contact your medical provider, submit BMI's information as the secondary insurance, and the provider will bill BMI directly with the itemized bills and primary EOBs.**

What insurance information do I have to give a provider? What is the policy # and Group #?
When you go to hospital, Doctor's office, PT clinic, etc, you must remember to tell them you have secondary insurance through your school's student accident medical insurance policy. Instruct the provider to bill your primary insurance first and then send the primary EOB and the itemized bill to BMI Benefits, LLC. **If you did not submit the secondary insurance information upon your first visit, please call the provider and give them the secondary insurance information for BMI Benefits.** If the provider bills the school's student accident insurance policy directly, this should prevent a balance due statement from being sent to the student/parent. **Policy ID #: Student Initials & DOB (IE: TAM 1212002) Group #: School Name**

What can cause a delay in processing and paying a claim?
The claims administrator cannot process a claim that is missing one or more of the following documents: the accident/injury claim form, the Itemized Bill or the Primary EOB / denial. We cannot accept balance due, balance forward, or past due statements for claims processing.

Who can I contact if I have any questions? If you have questions after you submit your claims to BMI Benefits, LLC. please contact them at 800-445-3126 or BMI@bobmccloskey.com. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim.

ITEMIZED BILL FOR PHYSICIAN BILLING - HCFA 1500 FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

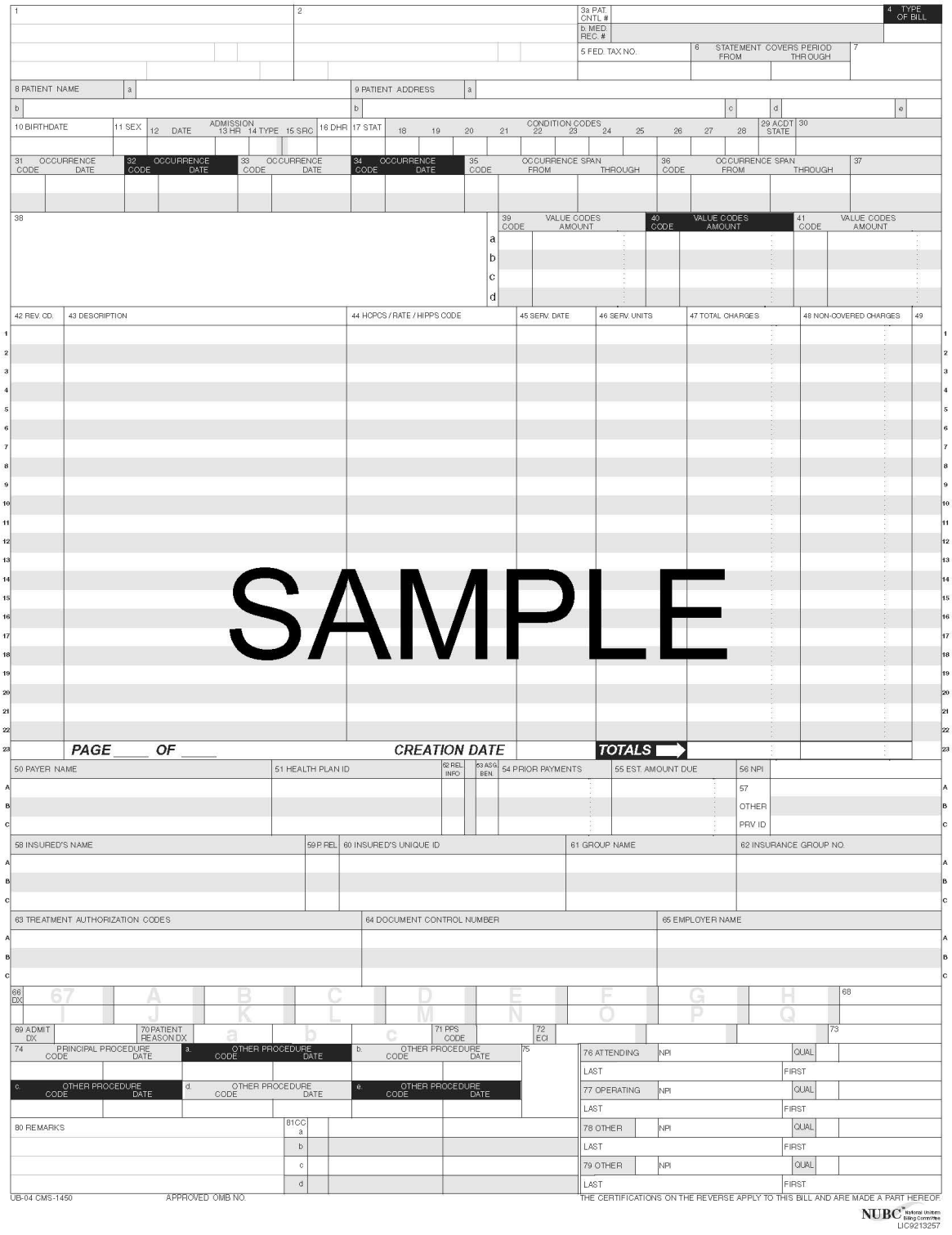
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number	17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) -

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

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