DOCUMENTING AN ACCIDENT and FILING AN INSURANCE CLAIM

There are one or two forms that must be completed by the troop leader or supervising adult if there is an accident while a registered girl or adult member or insured tagalong is at an approved supervised Girl Scout activity.

1. **Girl Scouts of West Central Florida Incident/Accident Information Report form** documents the details of *any* incident or accident, even if outside medical attention was not required. The troop leader or event director completes the form (front and back) and sends it to the Leadership Center immediately after the incident or accident, whether or not it is expected that an insurance claim will later be filed. Do not hold the Incident/Accident Report pending completion of the insurance claim form. Send the form to Girl Scouts of West Central Florida, 4610 Eisenhower Blvd., Tampa, FL 33634, Attn: Heather Navratil. You may also email hnavratil@gswcf.org or fax the form to 813.262.1771.

2. **Girl Scouts of the U.S.A. Claim Form** provides information required for claim processing with GSUSA's insurance company if outside medical care was required. The insured must have been treated by a legally qualified health care provider within 30 days of the injury to be considered for payment or reimbursement. The insurance claim form is in three sections.

a) **Claimant Information.** The injured adult or the parent/guardian of the injured child completes page one.

- If you are able, attach itemized billings complete with diagnosis, dates and procedure codes. If expenses have been paid or reimbursed by the family's insurance, the adult/parent also submits a copy of the Explanation of Benefits. The submitting adult then sends the package to the troop leader or event director. We recommend keeping copies of all documents.

b) **Girl Scout Leader Statement.** The troop leader or event director completes the "Girl Scout Leader Statement" on the top of the second page, except for the "COUNCIL USE ONLY" line.

Ensure that all information to that point is provided, or the claim form may be returned for completion. Verify that the parent/guardian has included the family's insurance company name and policy number, since in most cases Girl Scout insurance coverage is secondary to the family's insurance. Send the form to Girl Scouts of West Central Florida, 4610 Eisenhower Blvd., Tampa, FL 33634, Attn: Heather Navratil. You may also email hnavratil@gswcf.org or fax the form to 813.262.1771.

c) Council Use Only. The Director of Governance and Corporate Administration will certify the claim on behalf of the council, and will enter the Claim Plan, Enrollment Number and Claimant's ID number at the top of the first page.

For further information contact:
Heather Navratil, Director of Governance & Corporate Administration,
813.262.1771, hnavratil@gswcf.org

4610 Eisenhower Blvd.
Tampa, FL 33634
(813) 281-4475

girl scouts of west central florida
Fax: (813) 262-1771
Email: hnavratil@gswcf.org

INCIDENT / ACCIDENT INFORMATION REPORT

Name of injured person/subject of incident:_____

Injured person/subject's address: _____

Injured person/subject's phone: _____

If child, parent(s) name: _____

If adult, emergency contact person name and phone: _____

Date of incident/accident: _____ Time of incident/accident: _____

Location of incident/accident (name/address): _____

_____

Person(s) involved: _____ Age: _____

_____ Age: _____

_____ Age: _____

Explain details of incident/accident: _____

_____

_____

_____

Witnesses (name, address and telephone):

NAME	**ADDRESS**	**PHONE**

Complete and submit this report for any injury (whether outside medical care was required or not) or any incident that needs to come to the attention of senior council management.

Actions Taken

What was done? _____

_____

_____

Who was called? _____

_____

Was the person transported to an outside medical care facility? ☐ Yes ☐ No

If yes, where and by whom? _____

_____

Explain treatment, if any: _____

_____

_____

Was any type of medication administered? ☐ Yes ☐ No

If yes, what? _____

Submitted by: _____ Phone: _____

Address: _____

Girl Scout Position: _____ Date: _____

Mail report to:
Girl Scouts of West Central Florida, Inc.
Attn: Heather Navratil
4610 Eisenhower Blvd.
Tampa, FL 33634
or
Fax to (813) 262-1771
or
Email to hnavratil@gswcf.org

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: _____
(Applicable to Optional Coverages only)

Name of claimant		Identification Number		Age	Date of Birth

Claimant's address	Number and Street	City	State	ZIP Code
		Tampa	FL	33634

If claimant is a minor, name of parent or guardian			Phone Number
Girl Scouts of West Central Florida	320		( ) -

Address of parent or guardian	Number and Street	City	State	ZIP Code
		Tampa	FL	33634

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
Girl Scouts of West Central Florida	320	(813) 281 - 4475

Council's address Number and Street	City	State	ZIP Code
4610 Eisenhower Blvd	Tampa	FL	33634

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