



United Church of God

an International Association

May 2, 2017

Dear Injured Camper or Staff Member and Family:

We are sorry to hear that you sustained an accidental injury at one of our camps. The following pages contain the claim form for our Camp and Conference Specialty Insurance.

United Church of God and the Camp Director are only responsible for completing Section I of the claim form. After that has been completed, **it is your responsibility** to ensure that the additional sections are completed and that the claim is filed. Here are some things to be aware of to make sure your claim is filed correctly and in a timely manner.

This specialty insurance is not handled the same way as insurance you might have through an employer, so many medical providers may not want to handle filing the claim for you or may not know how to handle it because they cannot submit it electronically.

Even if the facility has indicated that they will be filing the claim, we also recommend that you keep your own copy of this attached claim form, once completed, and obtain the itemized bills from the facility as soon as they are available, and mail the claim yourself.

Please note that Nationwide must receive written notice about your claim within 30 days after your injury. So even if you do not have all of the paperwork and bills in the 30 day time frame, please make sure that they are notified with as much information as you would have ready at that time. The completed claim form with supporting documents must be received by them within 90 days after your injury.

All communication about your claim should be sent to the address in Springfield, Massachusetts. You can access the full policy on-line at: <http://ucg.org/camp-accident-insurance>

Sincerely,

Chris Rowland
Insurance and Benefits Administrator
United Church of God

**NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY
NATIONWIDE SPECIALTY INSURANCE CLAIM FORM**

INSTRUCTIONS

THIS CLAIM CANNOT BE PROCESSED WITHOUT ALL OF THE BELOW INFORMATION AND STATEMENTS OF PAYMENTS FROM THE OTHER PLANS.

**CLAIM FILING INSTRUCTIONS
NOTE TO ORGANIZATIONS AND PATIENT**

Our objective at Nationwide Specialty Insurance is to provide fast and accurate claims service. Listed below are some instructions on claim submissions that, when followed, will assist us in providing this service.

PRIMARY COVERAGE

WHEN TO FILE A CLAIM

- Written notice of claim should be given to us within 30 days after the loss starts.
- Written proof of loss (the completed claim form and supporting documents) should be given to us within 90 days after the loss starts.

HOW TO FILE A CLAIM

- The organizational certification section (Section I) must be completed and certified by an official of the plan sponsor organization. It is very important that the policy number be shown.
- The insured (parent or guardian, if minor) must complete the insured's section (Section II) in full.
- Completion of the assignment section (Section III) is optional.
- Attach itemized bills showing the (a) patient's name, (b) diagnosed condition, (c) date(s) of treatment, (d) nature of treatment, and (e) charge per treatment.

WHERE TO FILE A CLAIM

Nationwide Specialty Insurance Claims
PO Box 420
Springfield, MA 01101
Phone: 1-800-525-8669
web address: ***www.GrouProtector.com***

NATIONWIDE LIFE INSURANCE COMPANY
 NATIONAL CASUALTY COMPANY
CLAIM FORM (please print or type)

GROUP INSURANCE

Submit to: Nationwide Specialty Insurance, PO Box 420, Springfield, MA 01101

SECTION I: TO BE COMPLETED IN FULL BY THE PLAN SPONSOR ORGANIZATION. Plan Sponsor Signature required (You may submit proof of membership or Certificate of Coverage in place of Plan Sponsor signature)

1. Policy Nbr _____ 2. Name of Plan Sponsor Organization _____
 3. Name of Patient _____ 4. Sex M F 5. School Grade _____
 6. Address of Patient _____
 Street City State Zip

COMPLETE IF ACCIDENT IS INVOLVED

7. Date and Time of Accident: ____/____/____ Time _____ AM PM
 DISMEMBERMENT/PLEGIA FATALITY
 8. **WHAT** injuries were received? _____
 9. **WHERE** did the accident take place? _____
 10. **HOW** did the accident take place? (be specific, explain exactly what happened) _____
 11. Did the accident occur:
 While taking part in an activity sponsored and directly supervised by the plan sponsor.
 Describe type of activity involved _____
 Name of Supervisor _____ Title _____
 Phone (____) _____
 During direct travel to or from the meeting place to take part in a Patient activity.

COMPLETE IF SICKNESS IS INVOLVED

12. Nature of sickness _____
 13. Date symptom first appeared ____/____/____
 14. Date of first expense resulting from the sickness ____/____/____

I certify that the above information is correct to the best of my knowledge and belief, that the person named in item 3 is insured by the policy, and that his or her insurance was in effect on the date the accident or sickness occurred. The signature can not be by the Patient, a Patient's spouse, son, daughter, father, mother, brother or sister, other relative or agent.

Signature of Plan Sponsor _____ Date ____/____/____
 Title _____ Phone (____) _____

SECTION II: TO BE COMPLETED BY THE PATIENT (PARENT OR GUARDIAN, IF MINOR)

15. Patient's Name _____ 16. Date of Birth ____/____/____
 17. Social Security Number ____/____/____
 18. Patient's Employer/Address _____

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give NATIONWIDE SPECIALTY INSURANCE CLAIMS, Columbus, Ohio, or it's legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

Signature of Patient _____ Date ____/____/____
 (Parent or Guardian, if minor) Phone (____) _____

SECTION III: ASSIGNMENT OF BENEFITS

I AUTHORIZE Nationwide Specialty Health Claims, Columbus, Ohio, to pay benefits in connection with this claim directly to the

doctor, hospital, or other supplier.

Signature of Patient _____ Date ____/____/____
(Parent or Guardian, if minor)



**NATIONWIDE MUTUAL INSURANCE COMPANY
NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY**

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Nationwide Life Insurance Company and Nationwide Mutual Insurance Company and National Casualty Company (collectively referred to as "Nationwide") are required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than Nationwide's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.

I understand that I am not required to sign this authorization form and that Nationwide will not condition coverage or the provision of payment to me on the signing of this authorization.

A SEPARATE FORM MUST BE COMPLETED FOR EACH ELIGIBLE PERSON. This form can be copied if additional forms are needed.

I, _____, hereby authorize the use or disclosure of health information about me as described below.
(Instructions for above: print eligible person's name if over age 17, or if age 17 or under, the eligible person's parent or personal representative.)

As parent or personal representative, I authorize the use or disclosure of health information about the eligible person who is age 17 and under, as described below.

1. Person(s) or group of persons authorized to disclose the information:

- Nationwide

2. Person(s) or group of persons authorized to receive and use the information from Nationwide.

Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with Nationwide, and to receive health information which Nationwide maintains about you:

Spouse (write in name and address): _____

Family member and relationship (write in name and address): _____

Friend(s) or Other(s) and relationship (write in name and address): _____

3. Description of the information that may be used or disclosed:

- All health information pertaining to me or my minor dependent(s) or the eligible person, if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other policy related information.

4. I understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. If the person completing this authorization is the personal representative of the eligible person or dependent, describe your authority to act on this person's behalf. _____

6. As described in the Notice of Privacy Practices I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide in reliance on this authorization by sending a written signed and dated revocation to Nationwide Specialty Health, P0 Box 2399, Mail Code CO-01-26, Columbus, OH 43216-2399. A copy of the Notice of Privacy Practices is also available upon request at this address.

7. I understand that either my personal representative or I may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.

8. This authorization will expire 36 months after the policy termination date.

Eligible Person Signature _____

Date: _____

Personal Representative Name, if applicable (As described above in #5) _____

Personal Representative Signature _____

Date: _____

State Fraud Notices

(New York) 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.

(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.

(Arkansas) 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.

(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.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Colorado) It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(District of Columbia) WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny benefits, if false information materially related to a claim was provided by the applicant.

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

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

(Indiana) A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files 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.

(Louisiana) 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.

(Maine) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

(New Hampshire) Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(Ohio) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Virginia) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."