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

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.

EXCESS COVERAGE

If the policy is an EXCESS PLAN, we will not pay benefits for, nor can the deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under:

1. another insurance contract or prepayment plan;
2. a trustee, union, employer, or employee benefit plan;
3. Workers' Compensation (or similar occupational law); or
4. A government plan (except Medicaid and other public assistance plans), including one set forth by statute (such as Medicare)

WHEN TO FILE A CLAIM

- If the policy contains an EXCESS MEDICAL EXPENSE BENEFIT, YOU MUST FIRST FILE THE CLAIM WITH ALL OTHER PLANS (including major medical) so we may determine what benefits are payable.
- 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

- Have the plan sponsor complete and sign Section I of the claim form. Make sure all information is provided, including the plan sponsor name, policy number and information on how/when the accident or sickness occurred.
- The Patient (parent or guardian, if minor) must complete Section II in full.
  Completion of a claim form with false, incomplete or misleading information may be considered a criminal act, and because of the additional investigation time required, may result in processing delays. Before you submit a claim, please double check all of the information on the form to assure that it is accurate.
- If you want payment to be made directly to the provider or medical services, sign and date Section III.
- File the medical claim(s) with the other insurer(s) as soon as possible. Upon receipt of the explanation of benefit statement(s) from your other insurance company (ies) or plan(s) showing payment or denial of claim, submit a copy of the statement(s) along with the completed claim form and copies of all itemized bills to us for processing. An itemized bill normally lists the patient's name, diagnosed condition, treatment dates and charge per treatment, and including the name, address, and federal tax identification number of the provider of service.
- If there is NO OTHER INSURANCE COVERAGE, obtain a written statement from the Patient's/Parent' employer(s) verifying that no other coverage exists. Complete Steps 1, 2, and 3 from HOW TO FILE A CLAIM above and mail with the itemized bills to us for processing.
- Only one (1) completed claim form is required per accident or sickness. It is also essential that correspondence clearly identify the plan sponsor, policy number, and the patient's name.

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 40210157215050501 2. Name of Plan Sponsor Organization Crow River Valley League
Group's Name

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 ________
19. Spouse's Employer/Address ________
20. If a MINOR, Parent's Name/Address ________
21. Father's Employer (Name/Address) ________
22. Mother's Employer (Name/Address) ________
23. Is the Patient covered by any of the above employer's health plan or by any other plan? ☐ Yes ☐ No. If Yes, give the names and addresses of the insurance companies or plans, show the types of plans (group, HMO, individual, etc) and attach itemized copies of the expenses paid by them:

Basic Coverage with: ______________________ Type of Plan ______________

Major Medical with: ______________________ Type of Plan ______________

Other Coverage with: ______________________ Type of Plan ______________

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 Insurance 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 redisclosed 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. ______________________________________

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 Insurance, P0 Box 420, Springfield, MA 01101. 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: ____________

PLEASE BE SURE TO ATTACH ITEMIZED BILLS