

## How To File a Claim

The Claim Form (M18979) is prepared by the Girl Scout volunteer or another authorized person, usually one who was at the scene of the accident and familiar with the circumstances.

### **Volunteer's or Other Activity Representative's Procedures**

When a Girl Scout, Adult Member or participant is injured during a supervised Girl Scout activity, the volunteer should follow these directions to claim benefits.

1. Have Parent/Guardian of injured participant or injured adult participant complete and sign appropriate sections of claim form.
2. Volunteer or Activity Representative must complete and sign the front of the Claim Form as soon as reasonably possible. Be sure to provide all the information required to expedite processing and to avoid delay.
3. Submit an itemized billing complete with diagnosis, date(s) and procedure code(s).
4. Keep a copy of all for your records.
5. Send the original to the Council for validation along with any available bills for covered expenses which have been incurred.

**Claims will not be processed without Council signature.**

### **Council Procedures**

1. The Council receives the completed Claim Form and reviews for: membership status or purchase of optional insurance, eligibility, presence of a bill and that the activity information provided is sufficient to confirm the claim is for a Girl Scout related accident (or illness).
2. The Activity Information section shown on the Claim Form must be completed. When marking this section, exercise good judgment (i.e., while at camp a girl falls over a log while walking across the beach. The Aquatic section should **not** be marked, as she was not in or on the water. The appropriate section is Slips/Falls and Other (carpet, log, stairs, etc.).
3. The Council Official's signature is required.
4. Councils should not sign blank forms and release to the volunteer. **Remember, United of Omaha relies on the Council to verify that the claim is for a Girl Scout related accident (or illness).**
5. Mark all appropriate levels (e.g., a Girl Scout Senior is serving as a Day Camp Aide or Resident Camp Counselor, check 4. Senior and 9. Seasonal Staff).
6. Send the original copy (with any bills) to:  
United of Omaha Life Insurance Company  
Special Risk Services  
P.O. Box 31156  
Omaha, NE 68131
7. Retain a copy for Council records.

**Questions on insurance claims should be referred to the P.O. Box number shown in No. 6, or call 1-800-524-2324.**

Only the Insurance Company can interpret the coverage as it applies to a specific claim. United of Omaha cannot answer Girl Scout program questions.

**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**  
United of Omaha Life Insurance Company  
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
If claimant is a minor, name of parent or guardian			Phone Number ( ) -
Address of parent or guardian	Number and Street	City	State ZIP Code

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.

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

**GIRL SCOUT LEADER STATEMENT**

Troop Number \_\_\_\_\_ Level: 0  Daisy 3  Cadette 6  Nonmember Child 9  Seasonal Staff  
 1  Brownie 4  Senior 7  Nonmember Adult 51  Ambassador  
 2  Junior 5  Adult Member 8  Staff

Name of Council	Council No.	Phone Number ( ) -
Council's address	Number and Street	City State ZIP Code

Date and place of accident or sickness	Date and location	Nature and details of injury or sickness
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Activity information	Type of activity (check below): 1. <input type="checkbox"/> Autos/Vehicles <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian 2. <input type="checkbox"/> Slips/Falls on/at/over/from <input type="checkbox"/> Equipment/Furniture <input type="checkbox"/> Animals <input type="checkbox"/> Other (carpet, log, stairs, etc.) 3. <input type="checkbox"/> Using Tools <input type="checkbox"/> Saw <input type="checkbox"/> Knife <input type="checkbox"/> Stove <input type="checkbox"/> Kiln <input type="checkbox"/> Other 4. <input type="checkbox"/> Aquatics (in/on water) <input type="checkbox"/> Swimming/Diving <input type="checkbox"/> Boating/Canoeing <input type="checkbox"/> Water Skiing 5. <input type="checkbox"/> Poisonous Plants/Insects (poison ivy/bee stings) 6. <input type="checkbox"/> Skating <input type="checkbox"/> Roller <input type="checkbox"/> Ice 7. <input type="checkbox"/> Illness/Sickness 8. <input type="checkbox"/> Other Accident
Overnight events	Was this an overnight event? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <span style="float: right;">Date</span> _____ Street Address <span style="float: right;">City</span> <span style="float: right;">State</span> <span style="float: right;">ZIP Code</span> Did injury occur during course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Claims covered by the Council's workers' compensation policy should not be submitted to United of Omaha.</b>
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 <span style="float: right;">Date</span>

### 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



# FRAUD STATEMENTS

## IMPORTANT NOTICE

Your coverage is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with our itemized bill and this completed form.

**Payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.**

- \*\* **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- \*\* **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.
- \*\* **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.
- \*\* **Arkansas:** Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- \*\* **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 purposes 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 award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- \*\* **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement containing any false, incomplete or misleading information is guilty of a felony.
- \*\* **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 insurance benefits, if false information materially related to a claim was provided by the applicant.
- \*\* **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.
- \*\* **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.
- \*\* **Kansas:** 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 as determined by a court of law.
- \*\* **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto 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.



