Claims Manual

Accident & Health

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GREAT AMERICAN INSURANCE COMPANY

Table of Contents

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A. Introduction

Great American Insurance Company understands the importance of choosing a financially strong company. We are an organization built for the long term and are committed to giving you that strength. Our policyholders benefit from our financial strength, underwriting expertise and customized coverage solutions.

Great American stands by our promise to provide outstanding claims service and expertise you expect from us. When you need to make a claim, you want to work with experts who understand your loss and what to do. That's why Great American works with Co-Ordinated Benefit Plans (CBP), a full service claims administrator.

Great American offers a wide array of accident and health Insurance coverages through our digital-focused pomi brand. The coverage provides comprehensive solutions for losses that may result from an accident. We service several niche industries including schools, daycares, camps, nonprofits, youth sports organizations, collegiate activities and health and fitness companies.

B. Co-Ordinated Benefit Plans - About Us

Co-ordinated Benefit Plans, LLC (CBP) is a nationally licensed, full service Third Party Administrator located in Clearwater, Florida. Founded in 1980, CBP continues to maintain a long and distinguished history of professionalism in servicing insurance carriers, sponsoring organizations and brokers.

CBP specializes in the administration of a wide variety of individual, affinity/association, financial institution and custom group plans to include: domestic and international travel insurance, accident and health insurance, student travel medical, GAP and hospital indemnity, special risk accident and health, AD&D, dental insurance, legal and personal expense protection plans.

CBP provides real-time administrative systems supporting premium payment options, claims administration, cost containment solutions, Web-based customer portal, agent compensation, dedicated Customer Care teams, customized Web Services, tailored reports, EDI, electronic payments, and Automated Claims Adjudication.

CBP focuses on efforts to ensure privacy and participates in periodic SSAE 16 reviews.

All administration and claim services are provided using dedicated, fully-automated insurance software systems with flexibility to accommodate the standards and directives of today's leading insurance companies and service providers. Extensive use of the internet brings the latest in customer service, provider relations and reporting services to meet our client's highest expectations.

C. How To File A Medical Claim To Co-Ordinated Benefit Plans

Step #1

Submit your completed Notice of Claim conveniently online at https://www.gaig.com/AHclaims or via email at GAICClaims@CBPInsure.com.

You can also scan the QR code to access the online form directly.

For assistance, contact Co-ordinated Benefit Plans at 877-477-4209.

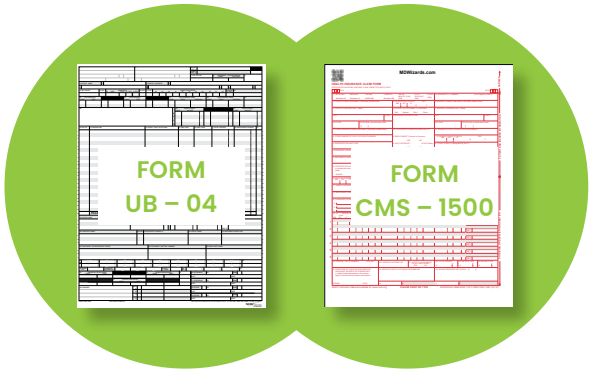
All claims forms are provided within this manual.

Please note: The Policyholder, Parent, Claimant or Authorized Representative should:

- ☐ Fully answer each item in Part A, Notice of Claim.
- ☐ Authorized Representative must sign Part A.
- ☐ The Parent/Guardian or Adult Claimant should:
- ☐ Fully answer each item in Part B, including other insurance questions.
- ☐ Review authorizations and sign after reading the fraud warning notices on last page of claim form.

Step #2

Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).



Provider
Provides to You

Primary Insurance Co.
Provides to You

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Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each injury/sickness. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form is not an admission or guarantee of coverage.
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges – examples above).
- Payment for medical bills is typically sent directly to healthcare providers unless proof of payment accompanies the claim. Acceptable proof of payment includes a copy of the check, receipt, or medical invoice confirming full or partial payment.

D. Exhibits-Claims Forms

Please note that there are two separate forms available for use as needed.

1. **Notice of Claim Form** – (Pages 7 through 10 of this PDF) To be used for participants, students and volunteers.
2. **Supplemental Loss of Life Document** – (Page 11 of this PDF)

Claim Filing Notice

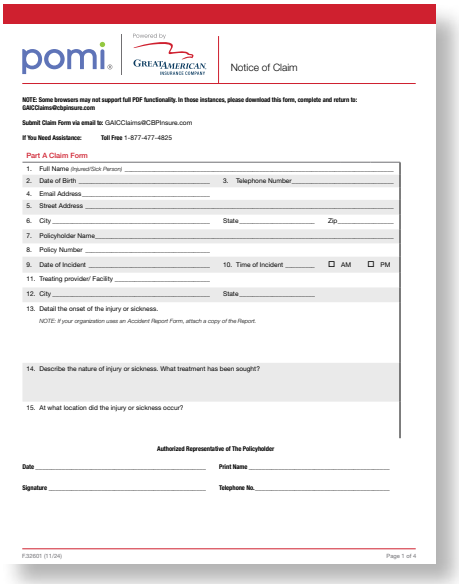
This claim form MUST be received by the Great American Insurance Company within 90* days of the date of injury.

*Unless otherwise noted in the Policy

Claim Procedure

1. Have a Representative of the Policyholder complete, date and sign PART A.
2. The Injured/Sick Person (Insured) – or, if the Injured/Sick Person is under age 18 or is otherwise dependent, his/her Parent or Guardian – MUST complete, date and sign PART B.
3. After PARTS A and B have been completed in full, submit claim form online or via email.

4. Send all medical bills to your other health and accident insurance company(s) first, if applicable. This can include employee plans, union plans, service contracts, HMO Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment from your other health and accident insurance company(s), notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to: GAICClaims@CBPInsure.com. You can also mail them to: Co-ordinated Benefit Plans, PO Box 21282, Tampa,FL 33622 or send via fax to: 800-561-8084. Please be sure to include your claim number.



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Notice of Claim

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Submit Claim Form via email to: GAICClaims@CBPInsure.com

If You Need Assistance: **Toll Free** 1-877-477-4825

Part A Claim Form

1. Full Name *(Injured/Sick Person)* _____
2. Date of Birth _____ 3. Telephone Number _____
4. Email Address _____
5. Street Address _____
6. City _____ State _____ Zip _____
7. Policyholder Name _____
8. Policy Number _____
9. Date of Incident _____ 10. Time of Incident _____ ☐ AM ☐ PM
11. Treating provider/ Facility _____
12. City _____ State _____
13. Detail the onset of the injury or sickness.
NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.
14. Describe the nature of injury or sickness. What treatment has been sought?
15. At what location did the injury or sickness occur?

Authorized Representative of The Policyholder

Date _____ **Print Name** _____

Signature _____ **Telephone No.** _____

F32601 (11/24) Page 1 of 4

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Notice of Claim

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Submit Claim Form via email to: GAICClaims@CBPInsure.com

If You Need Assistance: **Toll Free** 1-877-477-4825

Part A Claim Form

1. Full Name *(Injured/Sick Person)* _____
2. Date of Birth _____ 3. Telephone Number _____
4. Email Address _____
5. Street Address _____
6. City _____ State _____ Zip _____
7. Policyholder Name _____
8. Policy Number _____
9. Date of Incident _____ 10. Time of Incident _____ ☐ AM ☐ PM
11. Treating provider/ Facility _____
12. City _____ State _____
13. Detail the onset of the injury or sickness.

    NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.

14. Describe the nature of injury or sickness. What treatment has been sought?
15. At what location did the injury or sickness occur?

Authorized Representative of The Policyholder

Date _____ **Print Name** _____

Signature _____ **Telephone No.** _____

Part B

This PART MUST be completed, dated and signed by the Injured/Sick Person – or if the Injured/Sick Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

Print Here: Name of Person Completing Form _____

Check one: ☐ Injured/Sick Person ☐ Parent ☐ Guardian

Give the following information about the Injured/Sick Person:

1. Date of Birth _____ 2. ☐ Male ☐ Female

3. Social Security No. _____ 4. Area Code/Telephone No._____

4. Is the Injured/Sick Person covered under any other health and/or accident insurance plans? **Yes** ☐ **No** ☐

   If yes, give the following information:

   Name of Other Insurance Company(s)_____

   Street Address _____

   City _____ State_____ Zip_____

   Area Code/Employer Telephone No._____

   Policyholder Name_____

   Policy number_____

   Street Address _____

   City _____ State_____ Zip_____

   Social Security No. _____

   Relationship to Injured/Sick Person _____ Area Code/Telephone No._____

5. If the Injured/Sick Person is married, give the following information:

   Name of Spouse_____

   Social Security No. _____ Area Code/Telephone No._____

6. Is the Injured/Sick Person eligible for Medicare/Medicaid? **Yes** ☐ **No** ☐

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also authorize Great American Insurance Company or its agents or representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Great American Insurance Company from liability as to amounts so paid.

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 (in FL, a felony in the third degree), and in the state of New York, 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.

Signature *(in writing)* of Responsible Party _____ **Print Name** _____

Check one: ☐ **Injured/Sick Person** ☐ **Parent** ☐ **Guardian** **Date** _____

SEE FOLLOWING PAGE FOR FRAUD WARNING NOTICES

Fraud Warning Notices

AK: Any 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.

AL: 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.

AR, DC, LA, MD, NM, RI, TX, WV: 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.

AZ: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: 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.

CO: 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DE, ID, IN: 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.

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

KY: 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.

ME, TN, VA, WA: 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 denial of insurance benefits.

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

NH: 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 section 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: 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.

OH: 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.

OK: Any person who knowingly, and with any 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.

Fraud Warning Notices *Continued*

PA: 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.

ALL OTHER STATES: 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/or civil penalties.

Submit

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Loss of Life Document – Supplement to Claim Form

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Submit Claim Form via email to: GAICClaims@CBPInsure.com

If You Need Assistance: **Toll Free** 1-877-477-4825

Part A Claim Form

Full Name of Deceased _____

Last Permanent Address of Deceased _____

City _____ State _____ Zip _____

Date of Death _____

Date Deceased Sustained The Accidental Injury That Caused His/Her Death _____

Cause of Death _____

How did the accident happen?

Policyholder Name _____

Policy Number _____

Attending Physician at Time of Death:

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

In what capacity, or by what title, do you claim this insurance? _____

(Beneficiary, executor, assignee, guardian, trustee, administrator)

The undersigned hereby makes claim to said insurance from Great American Insurance Company and agrees that the written statements of all Physicians who treated and attended the insured are accurate to the best of their knowledge. The undersigned further agrees that all other documentation required and the instructions provided constitute the full scope of the Proof of Death and also agrees that by providing the other supplemental documents shall not constitute an admission that there was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

Dated _____**, 20** _____ **Signature** _____

Print Name _____ **Address** _____

City _____ **State** _____ **Zip** _____

CERTIFIED COPY OF DEATH CERTIFICATE MUST BE ATTACHED

Submit