# Wholesale Benefits Association
## How To File An AccidentShield Claim

**This is a guide to assist you with filing a claim. Please refer to your Description of Coverage for specific requirements.**

**STEP ONE:**
**You have 60 days after the accident to file your claim. Obtain the WBA claim form by going to:**

**http://www.wbaweb.com**

**Complete the Claim Form in its entirety, providing a description of the details of your accident as well as responding to all other questions on the form. If you are filing a claim for a dependent, be sure to include the dependent name in the field provided. Also, be sure to sign and date the form. Please be sure to sign and date the additional Information Release Authorization at the end of the form. This will allow WBA and your agent to assist Co-ordinated Benefits in processing your claim.**

**STEP TWO:**
Obtain detailed billing statements from all medical providers. Obtain Explanation of Benefits (EOB) statements from any other insurance. EOB's should accompany and match the medical bills you are submitting. EOB's alone or "Balance Due" bills are not acceptable. Obtain copies of any other items that relate to the injury (example: police report, accident report, etc.). If you have other insurance, your claim cannot be processed without an EOB from your other insurance carrier that indicates in detail what your other insurance carrier has paid on the claim. If you are requesting direct reimbursement for bills you have paid get proof of payment (cancelled checks, credit card statements, etc).

**STEP THREE:**
Assure that you have all of the required documents to file your claim:

- Completed and signed Accident Medical Claim Form with your WBA policy number and member number
- Explanation of Benefits (EOB) from any other insurance
- Detailed medical bills from all providers
- Proof of payment to medical provider if you are requesting direct reimbursement
- Other documentation you have pertaining to your accident (*example*: police report, accident report, etc.)

Send claims to:

Co-ordinated Benefit Plans
P.O. Box 23802, Tampa, FL 33623-3802
Phone: 1-866-224-6318

**DO NOT SEND ORIGINALS. Retain copies of all documents for your records.**

You will be contacted by Co-ordinated Benefit Plans (CBP) if additional information or documentation is required. CBP may request that you assist in following up with your medical providers to insure the rapid and accurate processing of your claim.

If you have any claim related questions please call CBP at the number above and advise the Customer Service Representative that you are a member of Wholesale Benefits Association (WBA). Please have your member identification number ready.

WBA has developed for its members an arrangement under which WBA may reimburse a portion of your deductible. Chubb & Son, a division of Federal Insurance Company and CBP had no part in the development of the deductible arrangement and is not responsible to ensure that claimants are paid pursuant to its terms. Any additional questions regarding payment of the WBA portion of the deductible should be directed to the WBA.

The furnishing of this information is not a waiver of any of the conditions of the insurance contract. This guide is not a binding agreement or a contract of insurance.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: 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, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or specific to AR and RI: 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 false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, specific to PA: subjects such person to criminal and civil penalties and specific to NY: 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.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (or specific to LA, TX and W VA: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or specific to NM: to civil fines and criminal penalties.)

Maryland: and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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: 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.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine/Washington: 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.

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

CHUBB GROUP
OF INSURANCE COMPANIES

# Request for Accident Medical Expense Benefits

## Accident Claim Form

MAIL TO:

Co-ordinated Benefit Plans
P.O. Box 23802
Tampa, FL 33623-3802
Phone: 1-866-224-6318

Group Name: Wholesale Benefits Association

Effective Date: _____

Paid to Date: _____

Policy Number: _____

Benefit Amount AME: _____

Instructions:

1) Insured Member must fully complete SECTION A. If claim is for dependent, complete dependent section in full.
2). Claim Form must be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3). BALANCE DUE STATEMENTS ARE UNACCEPTABLE. Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date(s) of service and the charge made for each service.

PLEASE MAIL COMPLETED FORM AND BILLS TO CO-ORDINATED BENEFIT PLANS.

The furnishing of this form, or its acceptance by the Company, must not be constructed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED IN FULL AND SIGNED BY CLAIMANT. THERE MUST HAVE BEEN AN INJURY DUE TO A COVERED ACCIDENT IN ORDER TO BE ELIGIBLE FOR BENEFIT CONSIDERATION.

| LAST NAME | FIRST | M.I. | SOCIAL SECURITY NUMBER | MEMBER ID NUMBER | DOB |
|---|---|---|---|---|---|
| | | | | | |

| ADDRESS (Street Address, PO Box, City, State, Zip Code) | PHONE NUMBER / E-MAIL ADDRESS |
|---|---|
| | |

| COMPLETE IF CLAIM IS FOR DEPENDENT: | NAME OF DEPENDENT | RELATIONSHIP TO INSURED | BIRTH DATE OF DEPENDENT |
|---|---|---|---|
| | | | |

| NATURE OF INJURY (Describe fully, including which part of body was injured) | DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED (Include date and time) |
|---|---|
| | |

| DATE FIRST TREATED BY DOCTOR | DOCTOR'S NAME |
|---|---|
| | |

| DATE LAST WORKED | DATE RETURNED TO WORK |
|---|---|
| | |

ARE YOU ENTITLED TO BENEFITS UNDER ANY OTHER INSURANCE POLICY COVERING THIS ACCIDENT ? YES ☐ NO ☐

Other insurance includes any health insurance, Workers Compensation, automobile insurance, homeowners or renters insurance, student accident or school insurance.

IF NO, PLEASE COMPLETE THE "CERTIFICATION OF NO OTHER INSURANCE" PORTION OF THIS FORM.
IF YES, PLEASE ATTACH COPIES OF STATEMENTS OF BENEFITS PAID OR DENIED AND COMPLETE THE FOLLOWING:
IS THE OTHER INSURANCE is A WORKERS COMPENSATION POLICY? YES ☐ NO ☐ ARE YOU SELF-INSURED? YES ☐ NO ☐

Please provide copies of official reports (police, fire, crime, etc.) that describe the circumstances of the accident

| NAME & ADDRESS OF INSURANCE COMPANY | POLICY # |
|---|---|
| | |

| NAME OF PERSON CARRYING OTHER COVERAGE | NAME OF EMPLOYER PROVIDING OTHER COVERAGE |
|---|---|
| | |

## CERTIFICATION OF NO OTHER INSURANCE

I, _____ , hereby certify that I have no other accident or health insurance or any other insurance covering this loss.

| Signature of Insured or Authorized Representative | Dated |
|---|---|
| | |

Co-ordinated Benefit plans does not share Private Health Information
except as required or permitted by law.
We are committed to guarding the Private Information entrusted to us.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.
BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

## AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I agree that a photographic copy of this Authorization shall be a valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

| Signature of Insured or Authorized Representative | Dated |
|---|---|
| | |

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## INFORMATION RELEASE AUTHORIZATION

I authorize Chubb & Son, a division of Federal Insurance Company (Chubb) and Co-ordinated Benefit Plans, LLC to release certain information regarding my claim, including my name, address and medical information, to Wholesale Benefits Association (WBA) and its agents to facilitate the administration of the claim and administration of the policy. I understand that any information I provide to WBA or its agents is governed by the privacy policy and procedures of the respective organizations and that these organizations are not Chubb service providers and Chubb is not responsible for their actions. This authorization shall be valid for 24 months and may be revoked at any time subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation. To revoke this authorization, contact Co-ordinated Benefit Plans,P.O. Box 23802, Tampa, FL 33623-3802 Phone: 1-866-224-6318

Signature of the Insured _____ Date _____