Section Five: Insurance and Risk Management

Contact: Linda Rice, Office of Risk Management
busyone@clemson.edu
864-656-3354

Accident and Illness Insurance must be purchased for all resident summer program participants ($0.45/person/day).

If your program participants are staying in the Clemson Residence Halls, the Summer Housing staff will purchase insurance for those residents and add it to your Housing bill.

For program participants that are housed off-campus or commuting on a daily basis, you must purchase insurance for them from the Office of Risk Management (Denise Godwin, godwinp@clemson.edu).

What is Covered by Insurance

Minor children (under age 18) enrolled in on-campus residential programs are covered 24 hours a day for their entire stay on campus. The children are covered because they are assumed to be under direct supervision from the time they arrive on campus until they leave.

Adults are not covered at all times. The insurance company will not accept claims for adults who are on their own time and carrying out their own activities, separate from the sponsored activities of the camp. Covered activities are defined as "Supervised camp or conference activities sponsored and/or endorsed by the plan sponsor and direct travel to and/or from such activities."

Any activity outside of the above would need to be covered under the adult’s own medical insurance policy.

Pre-existing conditions are not covered, nor are prescription refills, etc.

If a non-employee or volunteer needs treatment that is unlikely to be covered by the insurance policy, please advise him/her to go to a nearby Urgent Care facility. Redfern does not accept private health insurance.

If a participant must go to Redfern or a local Urgent Care or emergency facility, please be sure he/she is carrying the Insurance Identification Card (page 21) and a copy of the American Income Life (pages 19-20). Distribute these cards to all participants for identification when seeking health services whether you are using Redfern Health Center or another Health Care Provider.
How to File a Claim

1. Written notice of claim, or Claim Report Form, must be provided to the company within twenty days from the date of incident covered by this policy, but no later than ninety days from the date of incident.
   - Complete the entire claim report (Parts 1-6), the claim report must be signed by a camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT.
   - Valid claim reports must contain the following information:
     a. Policy number and serial number
     b. Full legal name of the injured/ill person (patient)
     c. Patient’s date of birth & age
     d. Current mailing address
     e. Date of the incident (injury or illness)
     f. How injury was sustained or the nature of the illness
     g. Verification signature by Camp Director, Extension Personnel, Group Leader, or Chaperone
     h. Signature for Release of Medical Information Authorization

2. Eligible medical statements must be provided within one year from the date of treatment.
   For claim review provide:
   a. Itemized statements for services rendered by physician or hospital, including diagnosis and procedure codes.
   b. Prescription receipts complete with patient’s name, Rx number, name of prescription, and price.
   c. Proof of payment along with an itemized bill if payment has been made.
      Proof of payment would be a paid receipt from provider, credit card receipt, or cancelled check.
   d. Explanation of Benefits for claims paid by personal insurance.

NOTE:
Payment is made directly to the medical provider unless otherwise indicated on the Assignment Form (Part 5).

Mail, Fax, or Email the completed Claim Report Form directly to the company.
DO NOT rely on medical providers to forward.

American Income Life Insurance Company
Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
Ph: 800-849-4820
Fax: 317-849-2793
Claim Department Email: claims@americanincomelifeco.com
Web: www.americaincomelifeco.com
# Claim Report Form

**PART 1**

Policy #: 5534  
Dates Person Was Insured: 
Name of Policy Holder/Group: Clemson University

**PART 2**

Name of Patient:  
Patient Date of Birth:  
Age:  
Sex: M/F  
Patient Home Address:  
City:  
State:  
Zip: 

**PART 3**

Injury - Illness Report

Date of Injury/Illness:  
Time:  
Group Activity:  
Nature of Injury or Illness:  
Was this condition already present before this person became insured?  
☐ Yes  
☐ No  
Describe How and Where Injury Occurred (explain fully):  
If yes, please explain: 

**PART 4**

If there was no medical treatment during insured period, was injury or illness reported to staff member?  
☐ Yes  
☐ No  

Office Use:

**Verification Signature**

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - UNRELATED to patient

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

☐ Camp Director  
☐ Extension Personnel  
☐ Group Leader  
☐ Other (define): 

Name of Camp:  

Contact (Print Name):  
Title:  
Signed:  
Day Time Phone:  
Email:  

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 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.

Contact the Claims Department with questions:  
Phone: (800) 846-4830  
Email: claims@americanincomelife.com  
Fax: 317-846-2793

Send completed claim forms to  
AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250
Assignment Form – Receipts must be enclosed

ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

I hereby authorize the American Income Life Insurance Company to reimburse eligible medical benefits on the above claim to:

Payee Name: ____________________________

Address: ____________________________

City: ______________ State: ______ Zip: ______

Phone #: ____________________________ Email: ____________________________

Date: ____________________________ Signed: ____________________________

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Signature of Patient/Guardian/ or Personal Representative: ____________________________ Date: ____________________________

Send completed claim forms to:
AIL-SFD, P.O. Box 50158, Indianapolis, IN 46250
Email: claims@americanincomelife.com
Fax: 317-849-2793
CLEMSON UNIVERSITY RISK MANAGEMENT INCIDENT/ACCIDENT FORM

To be completed for incidents involving injury or potential injury to employees, attendees, visitors and/or general public.

Name of injured person ___________________________ Date of Birth _____________

Home Address ____________________________________________________________________

Home Phone _______________________ Work Phone ___________________________

Details of Incident/Accident

Incident Date _______________ Time _______am/pm Location _______________________

Description of what happened_____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Report what you think contributed to the incident/accident ___________________________

______________________________________________________________________________

Was injured party taken to hospital or doctor? Yes ____ No___

If yes, name of facility __________________________________________________________

How injured-party was transported _________________________________________________

Type of injury (ex: cut, puncture, burn, slip & fall)__________________________________

State body part injured ___________________________ Right _____ Left _______

Witness to incident/accident - Name ______________________________________________

Address ___________________________ Phone ___________________________

Reported to security/police: Yes ____ No ____ Officer’s Name _______________________ 

Name of Police Department responding ____________________________________________

(Attach copy of police report to this form)

Report prepared by ___________________________ Phone __ Date __

Forward to Risk Management, E-306 Martin Hall, Clemson, S. C. 29634-5339
Fax (864) 656-4558, Phone (864) 656-3354