PART I ±32/,&<+2/'(5¶6 5(3257

PART II ±OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, naT Td (9 (T Td (9 (T Td (M -

Listed below are important instructions and comments about filing a claim.

Note: Benefit Period is 52 weeks from date of accident

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure answer and complete the section regarding OTHER INSURANCE STATEMENT ´ marking either yes or no, and signing the line for authorization, so that HSR and the doctors/hospital may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, E-mail, Fax or make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form