HSR
Health Special Risk, Inc.

Claimants are very often included under their parent's and spouse's medical insurance and/or have coverage through their employer. Please fully complete all the requested information below regarding other insurance coverage.

Claimant's Name:_____ Telephone:_____

Claimant's Employer:_____ Telephone:_____

Claimant Employer's Address:_____

Health Plan/Insurance Name:_____

Is the claimant covered under this policy? ☐ Yes ☐ No

Spouse's Employer:_____ Telephone:_____

Spouse Employer's Address:_____

Health Plan/Insurance Name:_____

Is the claimant covered under this policy? ☐ Yes ☐ No

Mother's Employer:_____ Telephone:_____

Mother Employer's Address:_____

Health Plan/Insurance Name:_____

Is the claimant covered under this policy? ☐ Yes ☐ No

Father's Employer:_____ Telephone:_____

Father Employer's Address:_____

Health Plan/Insurance Name:_____

Is the claimant covered under this policy? ☐ Yes ☐ No

Benefits are payable under your ***HSR*** plan on an excess basis, which means we are the secondary carrier to any other valid and collectible insurance or pre-payment plan. Please submit copies of your primary carrier's explanation of benefits or reason for denial. We are unable to determine our liability until all other carriers have paid their liability.

If you are **not entitled** to any benefits other than those of your plan with Health Special Risk, Inc., **the affidavit below must be signed, witnessed by an individual other than a family member, completed and returned to our office**.

As soon as we have your reply, we will give prompt attention to your claim.

AFFIDAVIT

The undersigned, being duly sworn, on oath, deposes and states that:

1. I have carefully read the above information that outlines the conditions of coverage for the claimant and all eligible dependents under the policy issued.
2. No insurance, Blue Cross-Blue Shield or any other type of benefits have been paid or are collectible on account of the medical expenses incurred because of the injury sustained by the claimant, except as noted.

I agree that should it be determined at a later date that there is other insurance collectible, to reimburse the insurance company to the extent of any amount collectible.

X_____ **X**_____

Signature Date Witness Signature (non-family member) Date

_____ _____ _____

Claimant's Name Policyholder Policy #

Health Special Risk, Inc. • Claims Department • HSR Plaza II • 4100 Medical Parkway • Carrollton, TX 75007
Telephone (972) 512-5600• Fax (972) 512-5820 • Email: claims@hsri.com