

## **INSURANCE COVERAGE FOR VOLUNTEERS**

All Scouters need to have a basic understanding of the insurance needs and the coverage relating to Scouting activities. It falls into three categories: 1) Comprehensive General Liability, 2) Automobile Liability, and 3) Accident and Sickness.

Listed below are brief outlines of insurance coverage provided by or through the Santa Clara County Council.

### **Comprehensive General Liability Insurance**

This coverage provides protection for the council directors, officers, all Scouting employees, Scouting units, chartered organizations, and volunteer Scouters (whether or not registered) with respect to claims arising in the performance of their duties in Scouting.

This liability coverage is primary for charter organization, their officers and all registered scout volunteers. There is no coverage for intentional or criminal acts.

Because of the high limits, volunteers should **NOT** be placed in a position where their assets are jeopardized because of a negligence liability claim or lawsuit.

### **Automobile Liability Insurance**

Every person who drives a car in connection with a Scouting activity **MUST** meet state minimum requirements of 15,000/30,000/5,000 and should carry a minimum of \$50,000/\$100,000/\$50,000 of automobile liability limits on their vehicle. Any vehicle carrying 10 or more passengers is required to have limits of at least \$500,000 combined single limit. The council's automobile liability insurance is excess of the insurance the owner of the auto carries, but does protect the owner above his limits for the council's \$15,000,000 limit of coverage.

### **Unit Accident & Sickness Insurance Plan**

The Santa Clara Council requires that every unit have a supplemental accident insurance policy. An accident and sickness insurance plan is offered by the Santa Clara County Council, (provided by Health Special Risk), it provides some financial protection for accidental injury and illness for all registered youth, volunteer leaders and seasonal staff; a prospective youth member or leader who visits a meeting is also covered. **Other guests are not covered.**

The plan provides year around coverage while; 1) participating in any activity approved and supervised by the BSA whether at a unit, district or council level. 2) Traveling to and from such events or activities. 3) At approved Scouting activities outside the council boundaries.

There are exceptions and limitations to this plan. It is not the purpose of this coverage to replace or diminish the need for family health insurance. Rather its purpose is to provide assurance that financial help is available to help meet emergency medical expenses should an injury or illness occur during a Scout activity.

There are additional benefits under this plan for loss of life, dismemberment, loss of sight, dental treatment, and ambulance insurance. Details of the plan are available at the council service center.

If you unit elects not to participate in the Council plan, then proof of insurance coverage must be provided at the time of recharter.

### **Serious Incidents**

All serious incidents, accidents, sickness or summons served on a volunteer, related to Scouting, must be reported to the Council Service Center immediately. Call (408) 280-5088 and speak with Ron Schoenmehl or Jason Stein.

## **Tour Permits**

Leaders often ask how important is a tour permit? A prudent and conscientious leader would want to do everything possible for a safe unit activity.

A Tour Permit is a checklist of those items a "prudent and conscientious" leader would do and uses to assure a safe trip. They'll know if your driver(s) have insurance and at what levels, the unit committee approves it, there is a pledge of performance and transportation considerations.

It is then approved by the council, which documents that you have done everything a "prudent and conscientious" leader would do. This is important, in a worst-case situation where an accident results in legal action and a lawsuit.

**A Tour Permit is required when units leave their immediate area.** The immediate area is defined by our council risk management committee as within the city limits of the community of the usual meeting location of the den/unit. *If in a non-incorporated community within Santa Clara County, the immediate area is defined as within the same zip code area.* National Tour Permits are required for all trips more than 500 miles. These permits should list the drivers' names and limits of automobile liability insurance carried. When chartering a bus or van, make sure to get a certificate of insurance from the owner. Be sure the minimum limits listed above are carried. Youth, leaders, and parents must ride in the cab of trucks and not in the back. Every person must be provided with a seat belt.

Travel to and from a Scouting activity is not considered part of the activity itself unless the transportation is planned as a part of the activity and a Tour Permit is filed as required. Transportation to and from a unit meeting is not part of the Scouting activity/meeting.

As a reminder, it is Council policy that one person on your trip must be youth protection trained and the top leader of your unit has completed basic training. (Also, National tour permits require all registered BSA adult leaders on the trip to have completed youth protection training.) All insurance coverage provided through the Santa Clara County Council is limited to official Scouting activities. If a Tour Permit is required, but not filed, the activity is not an official Scouting activity and insurance coverage could be jeopardized.

## **Two Deep Leadership Policy For All Trips**

The following leadership policy for all BSA trips and outings was approved by the National Executive Board.

It is the policy of the BSA that trips and outings may never be led by only one adult. Two registered adult leaders or one registered adult leader and a parent of a participant, one of whom must be 21 years of age or older, are required for all trips or chartered organization of any Cub Scout pack, Boy Scout troop, Varsity Scout team, or Explorer post/ship sufficient adult leadership must be provided on all trips and outings. If activities are coeducational, leaders of both sexes must be present.

The "safety rule of 4" requires that no fewer than four individuals, with a minimum of two adults, go on any back country expedition or camp out. If an accident occurs one person stays with the injured and two go for help.

Additionally, adult leadership requirements must reflect an awareness of such factors as size and/or skill level of group, anticipated environmental conditions and overall degree of challenge.

**A Guide to Safe Scouting** is a publication of the BSA, to inform our adult leadership of its policies on a broad range of topics. If your unit doesn't have a copy it may obtain one at the Scout shop or through our web site: <http://www.scccbsa.org>. Leaders are required to have a copy of this guide as stated on tour permit requirements.

## ***HOW TO SUBMIT A CLAIM***

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*You have been injured and you need to file a claim for consideration of benefits. How is that done? Below are basic items that need to be included in order to have your claim considered. Please keep in mind that we are not guaranteeing your claim will be paid, we are saying if all conditions are met, then this claim will be considered for payment.*

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There are three basic items that are required in order for a claim to be considered eligible for benefits.

1) **A Completed Claim Form**

Please be sure to neatly and fully complete your claim form. If you do not have a claim form, please call **HSR** for assistance. Your claim form must have a policyholder's authorized signature. The policyholder representative is an employee or other administrator that acts on behalf of the policyholder to verify your claim. The policyholder will typically be your BSA or LFL Leader.

2) **Copies of Fully Itemized Bills**

Please contact the providers of medical service directly for an itemized billing. An Itemized bill is usually in the HCFA-1500 or UB-92 format which means the bill should have a date of service, patient name, billing address and phone, provider tax identification number, procedural codes, and diagnosis code. If your bill does not have this information, please call the provider of service directly and request they mail it to us or call our office for assistance.

3) **Copies of Your Primary Insurance's Explanations of Benefits**

**The policy is excess to any other available source of medical benefits if the charges are greater than \$300.00.** This means that you must file your bills through your primary, or personal, insurance carrier prior to this policy responding. **If the total charges are less than \$300.00, we will pay without the other insurance coordination.** When your primary insurance company processes the charges, they will send you an Explanation of Medical Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

***IF YOU DO NOT HAVE ANY OTHER AVAILABLE INSURANCE COVERAGE, fully complete Part 2 of the claim form as directed above, indicating "NO" in response to each insurance question, if appropriate. You MUST sign the insurance portion of the form if you have no other coverage. Please remember that this is a signed and sworn legal document.***

For specific policy information, please call **HSR** to verify benefits. It is important to remember that policy wording or any verbal verification of benefits does not guarantee payment. It is important to remember that any statement of policy information does not guarantee the payment of any medical expense. Benefit determination can only be made once the entire claim and supporting documentation has been received and reviewed by the claims examiner.

Every policy has limitations on claim submission as well as on the benefit period, which is the period of time for which benefits are available for treatment for that injury from the date of injury. Treatment received past the benefit period is not eligible for benefits.

**CONTACT INFORMATION**

***Health Special Risk, Inc.***

4001 North Josey Lane

Carrollton, TX 75007

Toll Free Number 1-866-726-8870

Fax Number: 972-492-4946

Customer Service Email: [claims@hsri.com](mailto:claims@hsri.com)



BOY SCOUTS OF AMERICA

- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
- 3. MAIL TO HEALTH SPECIAL RISK, INC.



HSR Plaza  
 4001 North Josey Lane  
 Carrollton, TX 75007-1520  
 866-726-8870  
 Fax 972-492-4946

To be completed by BSA Leader  
 Council Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**PART 1 - BSA Leader's Statement**

Check One:  Tiger Cub  Tiger Cub Adult  Varsity Scout  Learning for Life - Explorer  Learning for Life - Non-Explorer  
 Cub  Scout  Venturer  Leader  Committee  Seasonal Staff  Other \_\_\_\_\_

Check Policy:  Council  Unit  Learning for Life  Campers & Special Events  National Events

Post Number	Team Number	Troop Number	Pack Number
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1. Name of Insured (Claimant)	2. Social Security Number - -	3. Sex _F _M	4. Birthday _ / _ / _
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5. Address of Insured Street	City	State	Zip
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6. Parent's name, address and telephone number (include area code)

7. What date did accident happen or sickness begin?	8. Nature of injury or sickness (indicate part of body injured - such as broken arm, sprained ankle, etc.)
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9. Describe how accident occurred - give details

<b>FOR DENTAL CLAIMS ONLY</b>	10. Indicate which teeth were involved in the accident	11. Describe condition of injured teeth prior to accident: <input type="checkbox"/> Whole, sound and natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial
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12. Name of event or activity	13. Name and title or supervisor
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14. Signature of policyholder representative X	15. Title	16. Date
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**PART 2 - Other Insurance Statement**

Do you/spouse/parent have medical/health care coverage through your employer or other source on you?  YES  NO  
 If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:  
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan?  YES  NO  
 If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:  
 Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES OF THEIR EXPLANATION OF BENEFITS ALONG WITH YOUR CLAIM.**

**IF NO OTHER INSURANCE OR HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**  
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

Signature of participant or parent X	Witness	Date
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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.

**Authorization to pay benefits to provider**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**Authorization for release of information**

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS**