

# *U.S. NAVAL SEA CADET CORPS*

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29 May 2003

## **NSCC ACTION LETTER 7-03**

From: Executive Director, U. S. Naval Sea Cadet Corps

To: Distribution

Subj: NSCC Accident/Sickness Medical Insurance

Ref: (a) NSCC Action Letter 3-03, Accident/Sickness Medical Insurance

Encl: (1) Policy Description/POCs for Insurance Claims  
(2) Nationwide Insurance Company Claim Form

1. **Purpose.** To advise NSCC personnel on filing of medical/sickness claims.
2. **Background.** NSCC action Letter 3-03 advised all NSCC personnel of a change in medical insurance companies and changes in coverage for all NSCC personnel. The new policy went into effect 15 March 2003. NSCC Personnel enrolled or re-enrolled **before** 15 March 2003 are under the old medical insurance plan with CIGNA. Personnel enrolling or re-enrolling **after** 15 March 2003 are under the new medical insurance plan with Nationwide Insurance Company. There is a major difference in foiling of any insurance claim depending on which company is servicing the insurance claim. Personnel under the old insurance plan must file a claim through NHQ. Personnel filing a claim with Nationwide Insurance Company will file their claim directly with Nationwide and NHQ will not be involved in the claim process. Action Letter 3-03 should be reviewed in its entirety along with this action letter to ensure all are thoroughly familiar with medical claims insurance procedures.
3. **Discussion.** This action letter provides additional information for filing claims with Nationwide Insurance Company. Enclosure (1) provides general policy information, the NSCC policy number, and phone numbers to assist in filing of claims with Nationwide Insurance Company. All personnel are reminded that the new NSCC accident/sickness policy is an "excess medical insurance plan." That is, each family's primary medical insurance policy will be in effect before the NSCC policy becomes effective. After the benefits of the family's plan have been used, the NSCC policy takes over. For personnel without any medical insurance coverage, the NSCC coverage becomes the primary policy plan to cover NSCC members when participating in NSCC activities. Enclosure (2) is the claim form to be filled out by individuals making insurance claims under the new policy. This form is to be completely filled out and mailed/faxed to Nationwide Insurance when filing a claim. Please note there is space which requests information on the background of the injury. This information on this form is in addition to the NSCC Accident Report (NSCADM 022) information. COs, COTC and units shall ensure the

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NSCC Accident Report is filled out on all accidents/sicknesses for which there is the slightest possibility of a medical insurance claim being filed or needed to pay for the injury or sickness. It is better to have the information taken immediately while memories are fresh than to wait and try to reconstruct the information later. A copy of the NSCC Accident Report shall be retained in the local records of the unit, a copy given to the cadet involved, and a copy mailed to NHQ. In the event an insurance claim is submitted to Nationwide, the NSCC Accident Report will already have the information available.

4. Action. All unit commanding officers shall brief all unit personnel on the NSCC Accident and Sickness Policy. This briefing shall ensure the parents/guardians are fully aware the new medical policy is an "excess plan." Further, the parent's policy will be in effect first before the NSCC Accident/sickness insurance policy comes into effect. The briefing officer shall also ensure that the parents/cadets are aware that filing of the accident/sickness report to Nationwide Insurance Company is the responsibility of the cadet and his/her family. For privacy reasons, NHQ will not be allowed to intervene on a cadet's behalf with the insurance company. All commanding officers shall make several copies of enclosure (2) and retain on board to assist the cadets when/if they file a medical insurance claim. Claim forms may be requested from Nationwide Insurance Company at the number listed. The NSCC NHQ point of contact is Ms. E. Tadle.

5. **Cancellation**. This action letter is cancelled upon incorporation of its contents into NSCC manuals and regulations.



M. D. FORD

Distribution:  
Commanding Officers---Units/Training Contingents  
Regional Directors/Associate Regional Directors  
Field Reps  
NSCC Board of Directors



May 8, 2003

U.S. Naval Sea Cadet Corps  
2300 Wilson Blvd.  
Arlington, VA 22201-3308

Re: Accident and Sickness Coverage  
For Cadets

Dear Mr. Ford:

Thank you for selecting Nationwide Insurance for your insurance needs.

Your policy number is 502-95-21736. The benefits under this policy are as follows:

ACCIDENTAL DEATH AND SPECIFIC LOSS  
 With a \$250,000.00 overall maximum for any one  
 Accident

Death -----	\$ 5,000.00
Specific Loss -----	10,000.00

MEDICAL EXPENSE  
 Accident

Deductible -----	None
Overall Maximum -----	25,000.00
Sickness (Overall Maximum) --	5,000.00

Should you have any general claims questions, you can contact Mary Flory, Claims Group Leader at 1-800-525-9669 extension 43580. Ms. Flory **should only** be contacted regarding whether an accident would be covered or not. To check on the status of a claim, please contact 1-800-525-8669 option 3. Any examiner that answers the telephone would be able to give you the status of your claim.

Sincerely,

Carol Shaw  
Special Risks Health  
Nationwide Insurance

ENCLOSURE (1)

NATIONWIDE LIFE INSURANCE COMPANY

- SEE INSTRUCTIONS ON REVERSE SIDE -

CLAIM FORM

SPECIFIED HAZARD INSURANCE (please print or type)

GROUP INSURANCE

DELAWARE, INDIANA, AND FLORIDA REQUIRED STATEMENT - ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE AND INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (THIRD DEGREE FELONY IN FLORIDA).

NEW YORK REQUIRED STATEMENT - ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME

OHIO REQUIRED STATEMENT - ANY PERSON WHO, 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

SECTION I TO BE COMPLETED IN FULL BY THE PLAN SPONSOR ORGANIZATION

1. Policy Number 502-95-21736 2. Name of Plan Sponsor Organization U.S. Naval Sea Cadet Corps (Group's Name)

3. Name of Insured 4. Sex [ ] M, [ ] F 5. School Grade

6. Address of Insured (Street) (City) (State) (Zip)

COMPLETE IF ACCIDENT IS INVOLVED

7. Date and Time of Accident: Date Time : [ ] A.M. [ ] P.M.
8. What injuries were received?
9. Where did the accident take place?
10. How did the accident take place? (Be specific, explain exactly what happened)
11. Did the accident occur:
a. [ ] While taking part in an activity sponsored and directly supervised by the plan sponsor. Describe type of activity involved Name of Supervisor Title Phone ( )
b. [ ] During direct travel to or from the meeting place to take part in an insured activity.

COMPLETE IF SICKNESS IS INVOLVED

12. Nature of sickness
13. Date symptoms first appeared
14. Date of first expense resulting from the sickness

I certify that the above information is correct to the best of my knowledge and belief, that the person names in item 3 is insured by the policy, and that his or her insurance was in effect on the date of the accident or sickness occurred.

15. Signed [X] 16. Date
16. Title 18. Phone ( )

SECTION II TO BE COMPLETED IN FULL BY THE INSURED (PARENT OR GUARDIAN IF MINOR)

19. Insured's Name 20. Birth Date / / 21. Social Security Number - -

22. Insured's Employer (Name and Address)

23. Spouse's Employer (Name and Address)

24. IF A MINOR - Parents (Name and Address)

25. - Father's (Employer (Name and Address)

26. - Mother's Employer (name and Address)

27. Is the insured covered by any of the above employer's health plans or by any other plan? [ ] Yes [ ] No If "Yes" give the names and addresses of the insurance companies pr plans, show the types of plans (group, HMO, individual, etc.), and attach itemized copies of the expenses paid by them:

Basic Coverage with Type of plan

Major medical with Type of plan

Other coverage with Type of plan

I certify that the above information is true and correct. I AUTHORIZE and doctor, medical practitioner, hospital, clinic, other medical and medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child whom I am either parent of guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent of guardian; to give to NATIONWIDE LIFE INSURANCE COMPANY, Columbus, Ohio, or its legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original.

24. Date 25. Signature of Insured [X] 26. Phone ( ) (Parent or Guardian, if minor)

SECTION III ASSIGNMENT OF BENEFITS - I AUTHORIZE Nationwide Life Insurance Company, Columbus, Ohio to pay benefits in connection with this claim directly to the doctor, hospital, or other supplier.

27. Date 28. Signature of insured (parent or Guardian, if minor) [X]

THIS CLAIM CANNOT BE PROCESSED WITHOUT ALL OF THE ABOVE INFORMATION AND STATEMENT OF PAYMENT FROM THE OTHER PLANS.