

COMPLETE AND RETURN THIS FORM TO:

Medical/Dental Accident CLAIM FORM



P.O. Box 390 Short Hills, NJ 07078

52-week benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

- 1. NAME:(first) (last)
2. ADDRESS: (city) (state) (zip code)
3. TELEPHONE #:
4. BIRTHDATE: / / SEX: Male Female SS#:
5. CLAIMANT IS A: Player Coach Official Other
6. ACCIDENT DATE: / / ACCIDENT TIME: am pm
7. BODY PART INJURED:
8. ACCIDENT OCCURRED DURING: Game Practice Tournament Camp/Clinic Other
9. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:
10. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURED:

SECTION II STATISTICAL INFORMATION (required)

- 1.NAME OF TEAM/CLUB:
2. TYPE: Competitive Recreational
3. LOCATION: On Field Indoor Spectator Area Other
4. SURFACE: Dirt Grass Outdoor Turf Indoor Turf
5. SURFACE CONDITION: Dry/Normal Wet/Rainy Icy Muddy
6. POSITION:
7. STATUS: HIT BY OBJECT COLLISION W/OPPONENT COLLISION W/TEAMMATE OTHER

SECTION III TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL (required)

Table with 4 columns: Policy Effective Date, Policy Expiration Date, Policy #, Name of Policyholder. Includes address and telephone number for USGAA.

VERIFY THAT THE ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER THE CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT. YES-SPONSORED/SANCTIONED ACTIVITY YES-CLAIMANT WAS AN ACTIVE MEMBER ON THE DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. AUTHORIZED SIGNATURE: TITLE: DATE:

SECTION IV**STATEMENT OF OTHER INSURANCE****(required)****Claimant/Father**

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Employer: _____

Phone: _____

Self Employed Unemployed

Email: _____

Claimant/Mother

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Employer: _____

Phone: _____

Self Employed Unemployed

Email: _____

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY?

YES NO

IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID?

YES NO

POLICYHOLDER NAME: _____ **ID#:** _____

INSURED GRP#/NAME: _____

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____

****Please include copy of insurance card (both sides)**

Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: _____

SECTION V**ASSIGNMENT OF BENEFITS****(required)**

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING PROVIDED INDICATES PAYMENT MADE BY YOU.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required): _____ **DATE:** _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by RPS Bollinger or Markel Insurance Company or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required): _____ **DATE:** _____