

Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM & BILLS TO:



Underwritten by: American International Group, Inc.



NAHGA Claim Services
PO Box 189
Bridgton, Maine 04009
(800) 952-4320
(207) 647-4569 Fax

IMPORTANT NOTICE:
If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, please send it to us with the corresponding itemized bills.

PART 1: POLICYHOLDER & INSURED

(1) School/Organization/Group Name		(2) Policy Number	
(3) Claimant - Last Name, First Name		(4) Claimant Social Security Number	(5) Claimant Type (please choose)
(6) Mailing Address where Insurance Info/Requests should be mailed		(7) City, State, Zip	
(8) Birthdate	(9) Male <input type="checkbox"/> Female <input type="checkbox"/>	(10) Home Phone	(11) Alternate Phone
(12) League (Example: Central Ohio)	(13) Association (Example: Columbus Titans)	(14) Team Description (please choose one)	
(15) If claimant is an adult, name and address of Employer:			

PART 2: INJURY DETAILS

(1) Date of Injury	(2) Time & Address where occurred?	(3) Sport (please choose one)
(4) Description of injury and how it occurred?		(5) Part of body injured
(6) Date of first medical treatment	(7) Action Taken: <input type="checkbox"/> Released to Parent <input type="checkbox"/> Ambulance Transport <input type="checkbox"/> Refused Care <input type="checkbox"/> Referred to Hospital/Clinic <input type="checkbox"/> Own Accord (Adult)	
(8) Was the claimant supervised when injured? Yes <input type="checkbox"/> No <input type="checkbox"/>		(9) Was injury during sponsored activity? Yes <input type="checkbox"/> No <input type="checkbox"/>
(10) Was injury during travel to or from scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/>		(11) If claimant is adult, is claimant unable to work as result of injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date last worked:
(12) Print Name of Supervisor/Official/Policyholder Representative	(13) Signature of Supervisor/Official/Policyholder Representative	Date

PART 3: PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)

(1) Father/Guardian Name Telephone	(7) Mother/Guardian Name Telephone
(2) Home Address (Street, City, State, Zip)	(8) Home Address (Street, City, State, Zip)
(3) Employer	(9) Employer
(4) Father's Employer Address (Street, City, State, Zip)	(10) Mother's Employer Address (Street, City, State, Zip)
(5) Business Phone	(11) Business Phone
(6) Employer Medical Insurance Policy	(12) Employer Medical Insurance Policy
(6a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>	(12a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>

PART 4: INSURANCE VERIFICATION

Is Claimant covered by any other insurance policy (other than this policy), either as an individual, dependent, group, automobile medical or liability? Yes No

If yes, please list name of insurance carrier: _____

Please note that if other insurance exists, all claims must be submitted to that other insurance policy first

PART 5: AUTHORIZATION

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Student to disclose when requested to do so, any information to NAHGA CLAIM SERVICES with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photo static copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.

X _____
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

X _____
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) Date

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.

Please follow these instructions to file a Claim:

- Complete front of claim form, in full;
- Sign Supervisory section, Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to NAHGA as soon as incident or illness is reported (form may be submitted without medical bills)
- Obtain and submit itemized bills, showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable).

FRAUD WARNING

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas or Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information, commits a felony.

Kentucky: 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.

Maine, Tennessee or Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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 AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. (PURSUANT TO 11 NYC RR86)

Ohio: 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.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between \$5,000 and \$10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.