

Claim Form

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries
1-800-524-2324



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SEE REVERSE SIDE FOR FRAUD LANGUAGE

To Be Completed By Organization/School

Policy Number: T5MP - 087428
Organization/School Name: Southern California Volleyball Officials Association
Address: _____

Phone No. (____) _____ - _____
Type of Activity _____

Name of team/sport (if applicable): _____
 Interscholastic/intercollegiate P.E. class _____
 Intramural Practice Game Jr. Varsity Varsity _____
(activity involved)
Dates of event (if student-date school started): _____

At the time of injury, was the insured involved in an activity sponsored by the Policyholder? Yes No
Under whose supervision? _____ Was he/she a witness? Yes No
If employed, was injury/sickness related to claimant's employment? Yes No

Type of Benefits Claimed

Accident-Medical Date of Accident _____ Hour a.m. p.m.
 Dental Location of accident _____
 Sickness-Medical Description of accident _____
 Loss of Time Type of injury or illness _____
First treatment date _____
Dates claimed _____

Dated: _____
Signature of Organization/School Official & Title _____

To Be Completed By Claimant — Or By Parent/Legal Guardian If Claimant Is A Minor

Claimant's Name: _____
Date of Birth: _____ Age: _____ Male Female

Address of Parents, Guardian or Claimant: _____
Home Phone No. (____) _____ - _____

Name and address of Family Physician: _____
Phone No. (____) _____ - _____

Has treatment been completed? Yes No

Father, Guardian or Claimant's (if adult) Employer, Name and Address: _____
Phone No. (____) _____ - _____

Mother or Spouse's Employer, Name and Address: _____
Phone No. (____) _____ - _____

Name of all companies providing your insurance coverage or prepaid health plans.

Name of Company	Address	Policy or Certificate No.
_____	_____	_____
_____	_____	_____

 Individual
 Group (Eff. Date _____)

Are benefits due for this claim under these other insurance coverages? Yes No (See reverse side for Important Notice)

I hereby certify that all above information is true and complete.

Signature _____ Date _____

IMPORTANT NOTICE

This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with our itemized bill and this completed form.

Payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

FRAUD STATEMENTS

The following fraud language is made part of and cannot be removed from this claim form. Please read thoroughly.

- ** **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.