AAU Registered Member
Sports Accident Claim Procedure

AAU members may be eligible for medical expense benefits for treatment of covered injuries sustained while participating in AAU Licensed activities.

If injured, complete a Claim Form and return it to A-G Administrators, Inc. via email, mail, or fax. Please retain a copy for your records.

The Claim Form must be signed by a non-relative coach, witness, Club Administrator or other AAU Organization Official.

Notes:

- If the injured Member is covered by another medical insurance policy, the bills must first be submitted to that Primary Carrier prior to the AAU excess accident insurance plan. The Primary Carrier will issue an Explanation of Benefits (EOB).
- All itemized bills should be forwarded to A-G Administrators, Inc. with the corresponding EOB from the Primary Carrier (see above).
- Each Claim is subject to a $300 deductible (Youth and Adult, Coaches, Volunteers & Officials)
- The Claim Form must be submitted to A-G Administrators, Inc. within 90 days of the accident/injury.
- The first medical treatment must be received within 90 days of the injury.
- Benefits are payable for covered expenses incurred up to 52 weeks from the date of injury.
- The maximum benefit offered by this plan is $50,000/injury.
- Payment will be made directly to the medical provider unless the paid receipt is included with submission.

Please submit Claim Form and related documentation to A-G Administrators, Inc.:

A-G ADMINISTRATORS, INC
PO BOX 979, VALLEY FORGE, PA 19482
(Phone) 610-933-0800 / (Fax) 610-935-2860
claims@agadm.com / www.agadministrators.com

FAIRMONT SPECIALTY
A member of the Crum & Forster Enterprise

Please complete this claim form by typing or printing clearly in ink and returning to:

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PO BOX 979, VALLEY FORGE, PA 19482
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The following must be completed, dated and signed by an official of the Organization

Name of Organization (Policyholder) Amateur Athletic Union of the United States, Inc. Policy Number US161173

❑ Athlete ❑ Non-Athlete ❑ Male ❑ Female Birthdate _____
❑ Youth ❑ Coach
❑ Adult ❑ Official
❑ Volunteer
Membership I.D. # _____

Name of Team/Club _____

Address of Team/Club _____
Number and Street City State Zip Code Phone No.

Name of Injured Person _____ Email of Injured Person _____

Part of body injured (include Left or Right) _____

Action Taken ❑ Released to Parent ❑ Ambulance Transport ❑ Refused Care ❑ Referred to Hospital/Clinic ❑ Own Accord (Adult)

Was injury during AAU licensed activity? ❑ No ❑ Yes Name of Event _____ License # _____

If the injury occurred during a non-licensed event, was the injured party an AB cardholder? ❑ No ❑ Yes

Date the injury was reported to A-G Administrators _____

At the time of injury, was the person involved in an activity under the jurisdiction of the Organization (Policyholder)?

❑ No ❑ Yes If yes, under whose supervision? _____

Was He / She a witness? ❑ No ❑ Yes

Did the injury occur during: ❑ Practice ❑ Travel ❑ Game ❑ Other _____

Date & time of injury _____ Date of 1st treatment _____

Type of Sport or Activity _____

Describe how and where accident occurred: _____

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Nature of injury_____

_____

Print Name of Organization Official_____Title_____

Organization Official's Signature_____Phone No_____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

NEW YORK FRAUD WARNING: 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.

AUTHORIZATION: I hereby authorize Fairmont Specialty, U.S. Fire Insurance Company or its representative to inspect or secure copies of medical records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous conditions, confinements or disabilities. I further acknowledge that this plan is not subject to the federal regulations commonly known as 'HIPAA'. A photo static copy of this authorization and acknowledgment shall be deemed as effective and valid as the original. I ALSO ACKNOWLEDGE THE ATTACHED FRAUD WARNINGS

SIGNATURE OF CLAIMANT_____ DATE_____
Or S**ignature of Parent/Guardian if Claimant is 18 years or younger**

AG ADMINISTRATORS
SPORTS INSURANCE SPECIALISTS

A-G ADMINISTRATORS, INC
PO BOX 979, VALLEY FORGE, PA 19482
(Phone) 610-933-0800 / (Fax) 610-935-2860
claims@agadm.com / www.agadministrators.com

FAIRMONT SPECIALTY
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THE FOLLOWING MUST BE COMPLETED BY THE INJURED PERSON OR IF THE INJURED PERSON IS UNDER THE AGE OF 18 OR OTHERWISE DEPENDENT – BY HIS/HER/ PARENT OR GUARDIAN

Member's Name _____ SS Number _____
Last Name First Name M.I.

Current Home Address _____
Number and Street City State Zip Code Phone No.

Date of Birth _____ ❑ Male ❑ Female Membership # _____

Employer Name _____

Employer Address _____
Number and Street City State Zip Code Phone Nor

PARENT (OR GUARDIAN) INFORMATION (must be completed if claimant is under 18 years of age)

Name of Father or Male Guardian _____ SS Number _____

Current Home Address _____
Number and Street City State Zip Code Phone No.

Employer Name _____

Employer Address _____
Number and Street City State Zip Code Phone No.

Name of Mother or Female Guardian _____ SS Number _____

Current Home Address _____
Number and Street City State Zip Code Phone No.

Employer Name _____

Employer Address _____
Number and Street City State Zip Code Phone No.

Is the claimant covered under any other insurance policy? No Yes

Name of Policyholder _____ Individual Group

Name of Carrier _____ Policy No. _____

Carrier's Address _____
Number and Street City State Zip Code Phone No.

Name of Policyholder _____ Individual Group

Name of Carrier _____ Policy No. _____

Carrier's Address _____
Number and Street City State Zip Code Phone No.

If other insurance exists, all claims must be submitted to the other insurance policies first. A copy of the itemized bills along with the other carrier's corresponding Explanation of Benefits should be submitted for consideration.

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CLAIM FORM FRAUD STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

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.

ALASKA and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

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.

FLORIDA: **WARNING:** 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.

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

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.

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.

OKLAHOMA: 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.

TENNESSEE and 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 denial of insurance benefits.

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