AAU Registered Member Sports Accident Claim Procedure

1. To file this form you must be an AAU member.
2. Complete a Sports Accident Claim Form, and mail it to NAHGA as soon as possible. Keep one copy for your records.
3. You must have a Non Relative Coach/Witness or Club Administrator sign the form.
4. You will receive a confirmation letter from NAHGA acknowledging receipt of form, assigning a case number, and providing instructions.

NOTE:

- Each claim is subject to a $200 deductible (for Youth, Coaches, Volunteers & Officials) or $500 deductible (for Adult participants)
- Sports Accident Form must be submitted to NAHGA within 90 days after the date of the injury/loss/incident.
- Injured member must seek treatment by a Physician within 60 days of date of injury/loss/incident.
- Benefits are payable for such covered charges that are incurred within 52 weeks from date of injury.
- Submit all claims to your primary insurance carrier first. If dental claim please submit to dental and health insurance.
- Signature of injured party or legal guardian is required.
- Direct payment for medical procedures **can not** be authorized by AAU or NAHGA. Payments for medical procedures can only be fulfilled by following the steps outlined above.
- Payment will be made directly to medical providers unless paid receipt is included with submission.

Submit Sports Accident Claim Form to via mail, fax, or email:

NAHGA Claims Services
88 Main Street
PO Box 189
Bridgton, ME 00409

Tel # 800-952-4320
Fax# 207-647-4569
Email: AAU@nahga.com

Ver. 8-28-12

Please print or type. Incomplete forms will be returned.

SEND COMPLETED FORM & BILLS TO:

SPORTS ACCIDENT CLAIM FORM

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

Underwritten by: Gerber Life

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) Amateur Athletic Union of the United States

(2) Policy: 09-071462-12

(3) ❑ Athlete ❑ Youth ❑ Adult
❑ Non-Athlete ❑ Coach ❑ Official ❑ Volunteer

(4) Claimant - Last Name, First Name

(5) Claimant Social Security #

(6) Mailing Address where Insurance Info/Requests should be mailed

(7) City, State, Zip

(8) Birthdate

(9) Male ❑ Female ❑

(10) Home Phone

(11) AAU Member ID

(12) Email

(13) AAU Club Name & Number

(14) District

(15) If claimant is an adult, name and address of Employer:

PART 2: INJURY DETAILS

(1) Date of Injury

(2) Address where occurred?

(3) Sport

(4) Description of injury and how it occurred?

(5) Part of body injured (include Left or Right)

(6) Date of first medical treatment

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

(8) Was injury during AAU sanctioned activity? Yes ❑ No ❑

(9) List Name of Event

(10) Sanction #

(11) Was injury at competition? Yes ❑ No ❑

(12) Was injury as Supervised Practice? Yes ❑ No ❑

(13) Was the claimant supervised when injured? Yes ❑ No ❑

(14) Was injury during travel to or from scheduled activity in a supervised group? Yes ❑ No ❑

(15) Print Name of Official/Coach/Club Representative

(16) Signature of NON RELATIVE Coach/Club Representative

(17) Phone

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

(6a) Is Claimant covered under that policy? Yes ❑ No ❑

(12) Employer Medical Insurance Policy

(12a) Is Claimant covered under that policy? Yes ❑ No ❑

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 Claimant to disclose when requested to do so, any information to NAHGA CLAIM SERVICES or authorized representative of the insurance carrier (SMIC) with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of 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.