

## AAU Registered Member Sports Accident Procedure

1. You must complete an AAU Registered Member Sports Accident Form, and mail it to NAHGA as soon as possible. Keep one copy for your records.
2. You will receive a confirmation letter from NAHGA acknowledging receipt of form, assigning a case number, and providing instructions on how to file for reimbursement.

### NOTE:

- Each claim is subject to a \$200 deductible.
- Sports Accident Form must be submitted to NAHGA within 90 days after the date of the 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.
- AAU, NAHGA, or Foy Insurance **can not** authorize direct payment for any medical procedures. Above reimbursement process must be followed for every medical bill.
- Payment will be made to directly to medical providers unless paid receipt is included with submission.

### Submit Sports Accident form to via mail, fax, or email:

NAHGA Claims Services  
3277 White Mountain Hwy  
PO Box 1760  
North Conway, NH 03860

Tel # 800-952-4320  
Fax# 207-647-4569  
Email: [AAU@nahga.com](mailto:AAU@nahga.com)

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



NAHGA Claim Services  
3277 White Mountain Hwy  
PO Box 1760  
North Conway NH 03860  
Tel # (800) 952-4320  
Fax # (207) 647-4569  
Email AAU@NAHGA.com

Underwritten by: National Union Fire Ins Co of Pittsburgh PA

**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: AAU REGISTERED MEMBER - SPORTS ACCIDENT FORM**

(1) Amateur Athletic Union of the United States		(2) Policy Number SRG-9101737	
(3) Claimant - Last Name, First Name		(4) Claimant Social Security #	(5) <input type="checkbox"/> Athlete <input type="checkbox"/> Non-Athlete (coach-volunteer)
(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) Phone #	(11) AAU Member ID
(12) Email		(13) AAU Club Name & Number	
(14) If claimant is an adult, name and address of Employer:			

**PART 2: INJURY DETAILS**

(1) Date & Time of Injury	(2) Address where occurred?	(3) Sport
(4) Description of injury and how it occurred?		(5) Part of body injured (incl Left or Right)
(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 injury during AAU sanctioned activity? Yes <input type="checkbox"/> No <input type="checkbox"/>		(9) List Name of Event
(11) Was injury at Competition? Yes <input type="checkbox"/> No <input type="checkbox"/>		(10) Sanction #
(13) Was the claimant supervised when injured? Yes <input type="checkbox"/> No <input type="checkbox"/>		(12) Was injury at Supervised Practice? Yes <input type="checkbox"/> No <input type="checkbox"/>
(15) Print Name of Coach/Club Representative/ or Witness		(14) Was injury during travel to or from scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/>
(16) Signature of Coach/Club Representative/Witness		(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	(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 Claimant 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 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.*