COMPLETE AND RETURN THIS FORM TO:

ACCIDENT PROOF OF LOSS/ CLAIM FORM

P.O. Box 1009 Morristown, NJ 07962-1009

365 day benefit period

SECTION I — TO BE COMPLETED BY PARENT/CLAIMANT (required)

1. **NAME:** (first) ______________________ (last)______________________________
2. **ADDRESS**: ______________________ (city) ______________ (state) ______(zip code)__________
3. **TELEPHONE #**:____
4. **BIRTHDATE:** ___/___/___ **SOCIAL SECURITY NUMBER** ______________ **SEX:** Male Female
5. **CLAIMANT IS A:** Player Coach Official Other
6. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** ________ am pm
7. **BODY PART INJURED:**____
8. **ACCIDENT OCCURRED DURING:** Game Practice Tournament Camp/Clinic Other______________
9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**______________________________

____

10. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**______________________________

SECTION II — STATISTICAL INFORMATION (required)

1. **NAME OF TEAM/CLUB**:____
2. **TYPE:** COMPETITIVE RECREATIONAL
3. **LOCATION**: ON FIELD INDOOR SPECTATOR AREA OTHER
4. **SURFACE:** DIRT GRASS OUTDOOR TURF INDOOR TURF
5. **SURFACE CONDITION:** DRY/NORMAL WET/RAINY ICY MUDDY
6. **POSITION:**____
7. **STATUS**: HIT BY OBJECT COLLISION W/OPPONENT COLLISION W/TEAMMATE
   OTHER______________________________________

SECTION III — TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL (required)

POLICY EFFECTIVE DATE	**POLICY EXPIRATION DATE**	**POLICY #**	**NAME OF POLICYHOLDER**

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	TELEPHONE NUMBER

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT.

YES-SPONSORED/SANCTIONED ACTIVITY
YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. **AUTHORIZED SIGNATURE:**	**TITLE:**	**DATE:**

SECTION IV STATEMENT OF OTHER INSURANCE (required)

Claimant/Father		**Claimant/Mother**	
NAME:________________		NAME:________________	
ADDRESS:________________		ADDRESS:________________	
CITY:________________		CITY:________________	
STATE: __________	ZIP:__________	STATE: __________	ZIP:__________
PHONE:________________		PHONE:________________	
EMPLOYER:________________		EMPLOYER:________________	
PHONE:________________		PHONE:________________	
SELF EMPLOYED	UNEMPLOYED	SELF EMPLOYED	UNEMPLOYED

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NO
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES NO

INSURED NAME: ________________ ID#: ________________ INSURED GRP#/NAME:________________

COMPANY NAME:________________________________

ADDRESS:________________________________

CITY: ________________ STATE: ________________ ZIP:________________

PHONE:________________________________

**Please include copy of insurance card (both sides)

Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY:________________________________

SECTION V ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantial civil penalty to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/CLAIMANT (required): ________________________ DATE:______________

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by OneBeacon Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT/CLAIMANT (required): ________________________ DATE:______________

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. Accident medical expense coverage under this policy is provided on an **Excess Basis** and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment.

2. **Claim Guidelines:** You have **90** days from date of injury to submit claim form.
   For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.

   Benefit Period: This policy is subject to a **365 day** benefit period from date of injury. Medical or dental expenses that are incurred **within 365 days** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **365 day** benefit period will not be covered by this policy.

3. **Please remember:**
   a) Advise your Providers/Hospitals of this insurance so they can file claims directly to OneBeacon.
   b) Attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
   c) **Itemized bills are required**: You must submit itemized bills; balance due bills will not be processed. See below for forms needed.

      1. HCFA-1500- standard form used by Providers
      2. UB-04 or UB-92-standard form used by Hospitals
      3. Payment of bills will follow the **usual and customary guidelines.** This means that the basis for payment of specific medical or dental claims is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the “usual and customary” fee for that service in your area.

4. **Dental bills:** All dental bills must be submitted through your primary insurance’s **medical and dental plans** first before submitting the bills to OneBeacon.

For further Claims information contact:

OneBeacon Insurance, Accident & Health Claims
P.O. Box 1009
Morristown, NJ 07962-1009
Phone: 866.630.6642
Fax: 866.638.4418

Please send the completed form to:
OneBeacon Insurance Company
Accident & Health Claims
P.O. Box 1009
Morristown, NJ 07962-1009

Authorization for Release of Information to OneBeacon Insurance Company

Name of Claimant:
Date of Birth:
Social Security Number:

I hereby authorize any health plan, physician, health care profession, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to OneBeacon Insurance Company and its agents, employees, and representative. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

I authorize any insurance company, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Occupational Accident, credit, financial, earnings, activities or employment history to OneBeacon.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to the authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that OneBeacon may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct legally permissible activities that relate to any coverage I have or have applied for with OneBeacon.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OneBeacon Insurance Company at: PO Box 1099, Morristown, NJ 07962. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OneBeacon has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the entire medical record, OneBeacon many not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

*Limits, if any:

Claimant Signature:	Date:	Date of Birth:
	Phone Number:	
Name (Please Print):		
Address:		

This authorization is intended to comply with the HIPAA Privacy Rule.