# NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for accident medical claims. **This form and all other correspondence must be submitted within 180 days from the date of accident.**

**Policies with Excess Coverage**
Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

**Policies with Primary Coverage**
Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

**Deductible**
If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

**Claim Form**
This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

**Medical Bills**
Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital.

**Information Requests**
In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

**Claim Submission Checklist**
Use the below checklist to assure a properly submitted medical claim is to be sent.

*If the injured person has primary health insurance has the claim been submitted first to the primary health insurance company?* _______

*If claim has first been submitted to the primary health insurance company, are copies of EOB's (explanation of benefits) attached?* _______

*Is part (A) of the claim form completed by the Policyholder official or staff member and signed?* _______

*Is part (B) of the claim form completed by the injured person and signed?* _______

*Are the attached medical bills itemized in either a CMS 1500 or UB04 form?* _______

*Is part (B), item number 3 (social security number) completed?* _______

Coverages underwritten by Berkley Life and Health Insurance Company and/or StarNet Insurance Company, both member companies of W. R. Berkley Corporation and both rated A+ (Superior) by A.M. Best.

**Mailing The Claim**
When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

A-G Administrators, Inc.
P.O Box 979
Valley Forge, PA 19482

**Emailing the Claim:** You may also email your claim documentation to **TERRYGREENTEAM@AGADM.COM**

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (610) 933-0800.

Documents may also be faxed to the claims office at (610) 933-4122. Please do not fax full medical claims, as often medical bills are illegible when faxed.

**PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanations of benefits are available for reimbursement. Claims must be submitted within 180 days of the date of accident.**

## ACCIDENT DEDUCTIBLE CREDIT SHEET

INJURED'S NAME: ______________________________

POLICYHOLDER'S NAME: ______________________________

DATE OF INJURY: ______________________________

NAME & ADDRESS CHECK SHOULD BE SENT TO:

______________________________

______________________________

______________________________

| PROVIDER | DATE OF SERVICE | $ AMOUNT APPLIED TO DEDUCTIBLE |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |

*If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your request, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.*

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# NOTICE

**Warning: FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED AT THE END OF THIS FORM.** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

| **PART A** – This PART **MUST** be **completed, dated** and **signed** by an official or the Organization. | | | | |
|---|---|---|---|---|
| 1. Name of Organization (Policyholder)<br>GFL Sports, Inc | | | | |
| 2. Policy No.<br>PAI L0140010679 | | | | |
| 3. Name of Organization or Team (if different from Policyholder) | | | | |
| 4. Address of Organization (Street) (City) (State) (Zip) | | | | |
| 5. Name of Injured Person (Insured) (First) (Middle) (Last) | | | | |
| 6. Date of Accident/Injury<br>Mo Day Year<br>/ / | 7. Injury Occurred:<br>Practice □ Travel □ Game □<br>Other ____________________________________ | | 8. Type of Sport or Activity: | |
| 9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report. | | | | |
| 10. Describe the nature of injury. | | | | |
| 11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes □ No □ | 12. Name of Supervisor of Activity | | 13. Was he/she a witness to<br>Yes □ No □ | |
| 14. Signature of Organization Official<br>**X** ________________________________ | 15. Title of Official | 16. Area Code/Telephone No.<br>( ) | | 17. Date Signed |

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**PART B** – This PART **MUST** be **completed, dated** and **signed** by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM — Check one: Injured Person ☐ Parent ☐ Guardian ☐

Give the following information about the Injured Person:

| 1. Date of Birth<br>Mo Day Year<br>/ / | 2. Male ☐<br>Female ☐ | 3. Injured Person's Social Security No. or Student Visa No.<br>/ / | 4. Area Code/Telephone No.<br>( ) |
|---|---|---|---|

**Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services.**

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ☐ No ☐
If YES, give the following information:

| Name of Other Insurance Company(s) | Address of Other Insurance Company(s) | Policy Number(s) | Name of Policyholder(s) |
|---|---|---|---|

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

Name of Mother or Female Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

9. If the Injured Person is married, give the following information:

Name of Father or Male Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: StarNet Insurance Company, Berkley Life and Health Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

**NEW YORK:** 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.

**X** ________________________________ ______________________________
Signature (in writing) of Responsible Party — Print Name

Check one: ☐ Injured Person ☐ Parent ☐ Guardian — Date: _______________

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# FRAUD WARNINGS

**Alabama -** Any person who knowingly presents 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 restitution fines or confinement in prison or any combination thereof.

**Arkansas -** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**California -** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in 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.

**DC -** 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.

**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.

**Georgia -** Any person who knowingly and willfully with intent to defraud subscribes, makes, or concurs in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false commits the crime of insurance fraud.

**Kentucky -** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

**Louisiana -** Any person who knowingly presents 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.

**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 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 FAUDULENT 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.**

**New York -** 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.

**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 -** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the Company. Penalties include imprisonment, fines and denial of coverage.

**Vermont -** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Washington -** 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.



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