NOTICE

This claim form MUST be received by the Insurance Company within 90 days of the date of Injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52 weeks after the date of accident

CLAIM PROCEDURE

1. Have an Official of the Organization **complete, date** and **sign** PART A.
2. The Injured Person (Insured) — or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian — MUST **complete, date and sign** PART B.
3. After PARTS A and B have been completed in full, mail the form to the address shown below **within 90 days** of the date of injury.
4. Send all medical bills to your other health and accident insurance company(s) **first**, if applicable. This can include employee plans, union plans, service contracts, H.M.O. Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment, notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown below.

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1. COMPLETE THIS FORM.
2. ATTACH ALL BILLS.
3. MAIL TO ➔

Linda Harris
ASqD Insurance Director
743 Pier Ave #2
Santa Monica, CA 90405
310-396-0739
linnberkk@aol.com

ACCIDENT CLAIM FORM
PLEASE PRINT OR TYPE

IF PARTS A and B ARE NOT COMPLETED **IN FULL**, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

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 (in FL, a felony in the third degree), and in the state of New York, 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.

PART A - This PART **MUST** be **completed, dated** and **signed** by an official of the Organization.

1. Name of Organization (Policyholder)

2. Policy No.

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 Mo. Day Year / /

7. Injury Occurred: Practice ☐ Travel ☐ Game ☐ 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 the accident? Yes ☐ No ☐

14. Signature of Organization Official X ______

15. Title of Official

16. Area Code/Telephone No. (   )

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 Mo. Day Year / /	2. Male ☐ Female ☐	3. Social Security No. / /	4. Area Code/Home Telephone No. ( )

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

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

Area Code/Employer Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident insurance plan(s)? 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 Spouse — Social Security No. / /

Place of Employment

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

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also authorize Legion Insurance Company or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Legion Insurance company from liability as to amounts so paid.

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 (in FL, a felony in the third degree), and in the state of New York, 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: __________

THE BENEFIT PERIOD FOR ELIGIBLE EXPENSES IS 52 WEEKS FROM THE DATE OF ACCIDENT