



USA VOLLEYBALL MEDICAL CLAIM FORM 2018-2019 Season

SEND THIS FORM TO:
 American Specialty Insurance & Risk Services, Inc.
 7609 W. Jefferson Blvd.
 Suite 150
 Ft. Wayne, IN 46804
 Customer Service Number: 800-245-2744
 Email: claimsPA@americanspecialty.com

This form should be completed whenever a medical claim results from an injury incurred at USA Volleyball sanctioned events.

PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY			
NAME (Last Name)	(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER
DATE OF BIRTH		SEX <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS (Street) (City) (State) (Zip Code)			
TELEPHONE NUMBER ()		OCCUPATION	
USA VOLLEYBALL PARTICIPANT #:		DATE & TIME OF ACCIDENT: ____/____/____ ____ AM ____ PM	
INJURED PARTY WAS: <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> COACH <input type="checkbox"/> OFFICIAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER: _____ IF PARTICIPANT, MEMBERSHIP TYPE: <input type="checkbox"/> JUNIOR MEMBER <input type="checkbox"/> ADULT MEMBER <input type="checkbox"/> NATIONAL OR HIGH PERFORMANCE TEAM MEMBER			
REGIONAL ASSOCIATION NAME:		COACHES NAME:	PHONE #: ()
NATURE OF INJURY			
FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:			
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT:			
B. DESCRIBE WHERE ACCIDENT HAPPENED:			
C. DESCRIBE HOW ACCIDENT HAPPENED:			
D. DID THE ACCIDENT OCCUR DURING: <input type="checkbox"/> COMPETITION <input type="checkbox"/> PRACTICE <input type="checkbox"/> TRAVELING TO/FROM <input type="checkbox"/> OTHER: _____			
E. WITNESS NAME: _____		PHONE #: _____	
IF INJURED PARTY IS A MINOR:			
PARENT/GUARDIAN NAME: _____		HOME PHONE #: _____	
EMPLOYER NAME: _____		WORK PHONE #: _____	
IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, NAME OF INSURANCE COMPANY		POLICY NUMBER	
ADDRESS (Street) (City) (State) (Zip Code)			
AUTHORIZATION TO RELEASE INFORMATION			
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.			
NAME OF PATIENT		SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)	DATE
I certify that the foregoing information is true and correct.		SIGNATURE	DATE

The completion of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.