



# PARTICIPANT ACCIDENT MEDICAL CLAIM FORM



This form is required to submit a Participant Accident medical claim for injuries sustained during a USA Water Ski & Wake Sports sanctioned event. **PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.** Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators: [usa-wsws@agadm.com](mailto:usa-wsws@agadm.com)

**TO BE COMPLETED BY INJURED PARTY (OR BY PARENTAL/LEGAL GUARDIAN IN CASE OF A MINOR)**

Organization Name USA Water Ski & Wake Sports

Participant's Name \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth \_\_\_\_\_ Sex  M  F SOCIAL SECURITY # \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_ 

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Home Address \_\_\_\_\_  
STREET CITY STATE ZIP

**USA-WSWS MEMBERSHIP STATUS:**  ACTIVE MEMBER  GUEST/BASICSKILLS MEMBERSHIP#:

**SPORT DISCIPLINE:**

- AWSA (3 Event)  Eastern Region  Midwest Region  Southern Region  South Central Region  Western Region  
 AKA (Kneeboard)  NCWSA (Collegiate)  NWSRA (Ski Racing)  USA-AWSWS (Adaptive)  
 ABC (Barefoot)  USW (Wakeboard)  NSSA (Show Ski)  USHA (Hydrofoil)

**TYPE OF SANCTIONED EVENT:**

- TOURNAMENT  PRACTICE  EXHIBITION  OFFICIALS CLINIC  BASIC SKILLS CLINIC  OTHER:

DID THE INJURY OCCUR DURING A USA-WSWS SANCTIONED EVENT?  YES  NO SANCTION #:

DID THE INJURY OCCUR WHILE TRAVELING TO/FROM THE EVENT?  YES  NO

NAME OF EVENT NAME OF SAFETY/CLUB OFFICIAL OR EVENT ORGANIZER: TEL. #  
NATURE OF INJURY: DATE OF INJURY: TIME OF INJURY:  AM  PM

**FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING**

- DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT:
- DESCRIBE WHERE ACCIDENT HAPPENED:
- DESCRIBE HOW ACCIDENT HAPPENED:
- WITNESS NAME

TELEPHONE #

**INSURANCE INFORMATION**

Does the claimant have primary insurance?  Yes  No (Attach separate sheet if necessary.)

Insurance Company Name & Address

Policy Number ID#

**AUTHORIZATION**

**AFFIDAVIT:** I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

**PAYMENT AUTHORIZATION:** I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

PARTICIPANT SIGNATURE (Parent or guardian, if participant is a minor)

Date

**FRAUD WARNING:** Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

**California & Texas Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Residents:** 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.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** 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.

**New York Residents:** 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.

**Tennessee Residents:** 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.

**Virginia Residents:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



Send all claim forms and documents using our secure upload portal: [upload.agadministrators.com](http://upload.agadministrators.com)  
Alternatively, submit documents to [usa-wsws@agadm.com](mailto:usa-wsws@agadm.com)