USA BOXING
MEDICAL CLAIM FORM

CHUBB
Underwritten by: FEDERAL INSURANCE COMPANY

Send this form to:
USA Boxing
1 Olympic Plaza
Colorado Springs, CO 80909

This form to be completed whenever a medical claim results from an injury incurred at USA Boxing sanctioned event.
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 ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)	TELEPHONE NUMBER ( )	OCCUPATION

USA BOXING MEMBERSHIP #:	DATE & TIME OF ACCIDENT: _____/_____/_____ _____ ___ AM __ PM

INJURED PARTY WAS:
☐ PARTICIPANT ☐ OTHER: _____

IF PARTICIPANT, MEMBERSHIP TYPE (PLEASE CHECK ALL THAT APPLY):
☐ ANNUAL MEMBER ☐ FOREIGN ATHLETE

NAME OF EVENT:	LBC OR CLUB REPRESENTATIVE	PHONE #: ( )

NATURE OF INJURY	SIGNATURE OF AUTHORIZED USA BOXNG NATIONAL HEADQUARTERS REP.

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:

☐ COMPETITION ☐ PRACTICE ☐ TRAVELING TO/FROM ☐ OTHER: _____

E. WITNESS NAME: _____ PHONE #: _____

IF YOU HAVE NO OTHER INSURANCE COVERAGE (IF UNEMPLOYED OR HAVE NO SPOUSE, PLEASE INDICATE SAME):

EMPLOYER NAME, ADDRESS AND TELEPHONE NUMBER:_____

SPOUSE EMPLOYER NAME, ADDRESS AND TELEPHONE NUMBER:_____

IF INJURED PARTY IS A MINOR AND YOU HAVE NO INSURANCE COVERAGE ON YOUR CHILD (IF UNEMPLOYED, PLEASE INDICATE SO UNDER EMPLOYER NAME):

FATHER- PARENT/GUARDIAN NAME: _____ HOME PHONE #: _____
EMPLOYER NAME: _____ WORK PHONE #: _____

MOTHER-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 OR AUTOMOBILE PLAN? ☐ YES ☐ NO

IS THE INJURED PERSON COVERED BY MEDICARE? ☐ YES ☐ NO If Yes, What is your Health Insurance Claim Number? _____

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 NAHGA Claim Services, 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

AUTHORIZATION TO PAY PROVIDER - I authorize payment associated with this incident directly to the physicians or providers.	IF YES, SIGNATURE	DATE
I certify that the foregoing information is true and correct.	SIGNATURE	DATE

The issuance of this blank 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.

USA BOXING MEDICAL CLAIM FILING INSTRUCTIONS

1. MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA BOXING.
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital, or other providers' standard Insurance billing forms: HCFA from physician or UB 92 from Hospital. These forms must show the following:
   - Patient's Name
   - Type of Treatment
   - Charges
   - Condition/Diagnosis
   - Date Expense Incurred
4. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have included employer insurance (spouse, parent or guardian), Medicare, Medicaid, Armed Forces or other coverage.
5. To expedite proper processing, submit completed form along with the above documents to:

<u>USA BOXING (First Report)</u>
United States Boxing, Inc.
1 Olympic Plaza
Colorado Springs, CO 80909
Phone: (719) 866-2323 Fax: (719) 866-2132

<u>Future Bills should be sent to:</u>
NAHGA Claim Services
P.O. Box 189
Bridgton, ME 04009
Phone: (800) 952-4320 Fax: (207) 647-4569

Important Fraud Notice

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona: For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who 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 or **Louisiana**: 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.
California: For your protection California law requires the following to appear on the form. 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: 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.
Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia: 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: 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.
Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Indiana: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information, commits a felony.
Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.
Maine, Tennessee or Virginia: 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 a denial of insurance benefits.
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
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA638.20.
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 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 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 (Pursuant to 11NYC RR86).
Ohio: Any person who, with 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 is guilty of insurance fraud.
Oklahoma: WARNING: 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.
Rhode Island: 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.
Pennsylvania: 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 subjects such person to criminal and civil penalties.
Texas: 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.
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.
West Virginia: 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

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete or misleading information or conceals any fact material thereto may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim are provided by the claimant

_____ _____

Signature of injured person (or parent/guardian if minor) **Date**