USA Wrestling Notice of Injury

In case of injury, the injured party, parent, or coach of the injured party should complete this form and mail it immediately to *USA Wrestling, 6155 Lehman Drive, Colorado Springs, CO 80918.* Call 1-719-598-8181 for any questions concerning your claim. This secondary sports accident insurance is a benefit of your membership in USAW. Coverage is provided via an outside carrier. A deductible applies in addition to other conditions of the policy. Instructions and details regarding coverage and the deductible will be mailed once this form is received and processed. This Notice of Injury form must be complete or it will be returned to the injured party.

Name of injured party _____ Birth Date _____ USA Wrestling Card # _____

Mailing address _____ City _____ State _____ Zip _____

Phone number ( ) _____ If injured party is a Minor, name of parent or guardian _____

E-mail _____

Injured party is a: ❑ Competitor ❑ Coach ❑ Official ❑ Other (describe) _____

Date of Accident _____ _____

Social Security # _____-_____-_____ _____

Where accident took place (check one)

❑ At a club practice ❑ At an event

Name of club _____ Name of event _____

City, State of Club _____ City, State of Event _____

Other (describe) _____

Describe the nature of the injury as best you can; naming body parts affected, etc. _____

_____

_____

Describe how injury happened; i.e. what move was being attempted, etc. _____

_____

_____

Primary health insurance company _____ Phone number ( ) _____

Address _____ City _____ State _____ Zip _____

Report submitted by: _____
Signature

Complete the following, if known:

Will the injured be off for more than 1 (one) week? ❑ Yes ❑ No Name of Doctor _____

Hospital referred to: _____ Address _____ City _____ State _____ Zip _____

Falsification of information on this report will void your benefits under USA Wrestling's Sports Accident Insurance Program

Please make sure that the form is filled out completely and mail it to:

USA Wrestling
Notice of Injury
6155 Lehman Drive
Colorado Springs, CO 80918

STATE USE ONLY

Verified by State ❑ Yes ❑ No

Date: _____

NATIONAL OFFICE USE ONLY

Club Verified	❑ Yes	❑ No
Event Sanction Verified	❑ Yes	❑ No
Membership Verified	❑ Yes	❑ No

Accident insurance coverage is available to protect insureds against accidental injury or death occurring while the policy is in force. Health Special Risk, Inc. is the administrator of this coverage.

Benefits are provided for covered expenses incurred within a certain time period after the date of the accident.

Full Excess means that benefits are payable for covered expenses that are in excess of other valid and collectible insurance.

You must submit your claim to your personal insurance company first. When you receive their Explanation of Benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.

CLAIM INSTRUCTIONS
In case of accident, notify the school immediately.

1. Treatment must commence within 90 days from the date of the injury.
2. Send this claim form to us within 90 days from the date of the injury. DO NOT leave this form with the school, organization, coach, hospital, physician, etc.
3. Do not leave any blank spaces or write "N/A" in a space. If either parent is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you do not have insurance, please state "no insurance". If you are employed, please provide us with a statement from your employer that the claimant has no insurance. Our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.
4. If claimant is insured under Medicaid, please indicate this.
5. Please attach itemized bills to the claim form or mail them as soon as possible. An itemized bill includes treatment rendered, the dates of the treatment, physician's or hospital's name, address and tax I.D. number, diagnosis, and procedure codes. Balance Due bills are not acceptable.
6. If you have other insurance, your insurance company will send you an Explanation of Benefits (EOB), which shows what they paid or denied. We need a copy of the EOB for each itemized bill submitted to us.
7. Or, your provider(s) may forward the itemized bills to us along with the corresponding EOBs.
8. Our address is Health Special Risk, Inc., HSR Plaza II, 4100 Medical Parkway, Carrollton, Texas 75007. Customer Service may be reached toll-free at 866-345-0959 or 972-512-5600. We will be happy to assist you.
9. Benefits are paid to the providers of service unless we receive paid receipts.

All policies have a limited benefit period. The insured will be covered for a minimum of one year from the date of the accident. For the exact benefit period of the claim, contact Health Special Risk, Inc. or your school/organization.

USA WRESTLING
SPORTS ACCIDENT INSURANCE PROGRAM
CLAIM FILING INSTRUCTIONS

The instructions below and the attached form(s) are provided for your help in expediting your secondary sports accident insurance claims with the Sports Accident Insurance carrier. Please follow all instructions and fill-out all forms completely.

1. If your minor child or you are injured while participating in a covered USA Wrestling event, please complete the attached Health Special Risk claim form and forward it to USA Wrestling. (Must be submitted within 1 year of date of injury.)
2. Please be reminded that medical service bill(s) related to your injury, occurring at a USAW sanctioned activity, must first be filed with your primary medical insurance carrier. Please also note medical attention has to be received within 90 days from date of injury.
3. IMPORTANT: In order to be eligible for any secondary sports accident insurance benefits, you must follow all requirements and conditions under your primary carrier's plan or policy.
4. The attached form(s), with supporting documents (see below) may only be filed after the claim(s) has/have been processed by your primary medical insurance carrier. (See #3 above).
5. Note that the Secondary Sports Accident Insurance coverage carries with it a $500.00 per membership year deductible and an 80/20 co-insurance limit up to $2,000.00 out-of-pocket, excluding deductible.
6. If your total medical bill(s), after being processed by your primary medical insurance carrier, (see #3 above), exceed $500.00 then proceed to #7 below. If you do not have a primary insurance carrier, then proceed to #9 below.
7. Please make copies of medical bill(s) and primary insurance carrier's "Explanation of Benefits" (EOB).
8. Once you have received an EOB report from your primary medical insurance carrier, submit items listed below to Health Special Risk, Inc., 4100 Medical Parkway, Carrollton, TX, 75007:

   What to submit:
   (a) Copy of the EOB.
   (b) Copy(ies) of itemized medical bill(s), which include diagnosis and procedure codes.
   (c) Copy of completed claim form.

9. If you do not have a primary medical insurance carrier, please complete the attached form and submit, with itemized medical bill(s) to:

   Health Special Risk, Inc., 4100 Medical Parkway, Carrollton, Texas 75007

10. You will also have to provide a notarized letter stating there is no other insurance in force for the injured party.
11. Keep a copy of each form and item submitted for processing.
12. If you have specific questions concerning your claim, please contact Health Special Risk, Inc. at 866-345-0959 or 972-512-5600; 9:00 AM to 4:30 PM (Central Time). Please have the social security number of the injured party and the date of the injury available for the service representative.
13. For general questions concerning Secondary Sports Accident Insurance benefits and coverage, please contact Shonna Vest, Membership Processing Assistant, at 719-598-8181, 8:00 AM to 5:00 PM (Mountain Time).

MultiPlan

HSR
Health Special Risk, Inc.

USAwrestling

1. Please fully complete this form.
2. Mail to:
USA Wrestling
Notice of Injury
6155 Lehman Drive
Colorado Springs, CO 80918

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (866) 345-0959

Wrestling Card Number:

FOR *HSR* USE ONLY: Claim Company #_____ Plan # _____ Location # _____

PART I – CLAIMANT/POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)	2. Social Security Number - -	3. Gender __M __F	4. Birthday ___ / ___ / ___	5. E-Mail

6. Address of Injured Person and Best Contact Phone Number (Include Area Code)

7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)

8. Date and Time of Accident	9. Place where Accident Occurred	10. The Injured Person was a: ☐ Competitor ☐ Coach ☐ Official ☐ Other

Dental Claims Only	11. Indicate which Teeth were Involved in the Accident	12. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) **Did Injury Result in Death? ☐YES ☐NO**

14. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident

15. Did Accident Occur (Check Yes or No for Each of the Following):

A.	**While at club practice?**	**☐YES ☐NO**
B.	**While at an event?**	**☐YES ☐NO**
C.	**On activity premises?**	**☐YES ☐NO**
D.	**While traveling directly and uninterruptedly to or from school and competition?**	**☐YES ☐NO**

16. Name of Club or Event	17. Name and Title of Supervisor

18. Name of Policyholder	19. Address of Policyholder (Address, City, State, Zip)
USA Wrestling	**6155 Lehman Drive, Colorado Springs, CO 80918**

20. Signature of Policyholder Representative	21. Title of Policyholder Representative	22. Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? **☐YES ☐NO**

If Yes: Name of insurance company _____ Policy #_____

Name of insurance company _____ Policy #_____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE

PART III - AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

FRAUD STATEMENTS

GENERAL: 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.

ALASKA, ARKANSAS, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this 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 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: 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.

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.

MARYLAND: Any person who, knowingly and with intent to defraud 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 fact material thereto, commits a fraudulent insurance act.

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 RSA 638:20.

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.

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.

OREGON: Any person who knowingly and with intent to defraud 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, may have committed a fraudulent insurance act.

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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

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.

VIRGINIA: 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.