SEND COMPLETED FORM TO:

NAHGA Claim Services
PO Box 189
Bridgton, ME 04009-0189
For questions call: 877.497.4980
Fax: 207.647.4569
Email: eiia@nahga.com

IMPORTANT!

- Initial medical treatment must take place within ***90*** days from the date of Accident.
- Written notice of a claim must be given within ***180*** days after a covered loss occurs.
- All eligible expenses must be submitted within one year from the date of service.
- All insurance you are covered by must be filed first before benefits will be considered.
- Please be sure you have provided your medical providers with a copy of your plan or ID card so they can bill directly!

EIIA

SECTION 1: *STUDENT STATEMENT— MUST BE COMPLETED & SIGNED BY STUDENT*

(1) School Name: _____ (2) Policy/Coverage Number: _____

(3) Student—Last Name, First Name: _____ (4) Student ID#:_____

(5) Street Address, City, State and Zip (all insurance info/requests will be sent to this address):

_____

(6) Phone Number & Email Address: _____

(7) Date of Birth: ____/____/____ (8) ☐ Female ☐ Male ☐ Gender Neutral (9) ☐ Domestic (U.S. Citizen) ☐ International

(10) This claim is for a(n): ☐ Accident ☐ Sickness/Condition (11) Date of Accident or Onset of Sickness: _____/_____/_____

(12) Did the incident occur due to participation in a(n)?: ☐ Intercollegiate Sport ☐ Club or Intramural Sport ☐ Not sports related

(13) If an intercollegiate, club or intramural sport – what is the name of the sport? _____

(14) If an Accident, describe how it occurred: _____

(15) Body Part Affected: _____ (16) If applicable: ☐ Left ☐ Right

(17) If Sickness, reason for seeking medical treatment: _____

(18) Have you previously been troubled by this condition/injury? ☐ Yes ☐ No (19) If so, when?: _____

(20) Were you seen and referred for treatment by the Athletic Department or Student Health Services? ☐ Yes ☐ No

SECTION 2: *INSURANCE STATEMENT*

If the student is under 26 years old and is insured, all the charges must be filed with the other insurance carrier first and copies of the Explanation of Benefits (EOBs) will be required for all charges submitted. INCOMPLETE CLAIM FORMS WILL BE RETURNED AND DELAY YOUR

(1) Is Student Insured? ☐ Yes ☐ No If yes, complete the information below:

(2) Insurance Company Name & Phone Number: _____

(3) Plan ID #: _____ (4) Is this a government funded plan (i.e. Medicaid or Military Insurance)? ☐ Yes ☐ No

SECTION 3: *INTERCOLLEGIATE SPORTS – To be completed by Athletic Department Official Only!*

☐ Please check if you are attaching the initial injury report in lieu of completing this section.

(1) At the time of injury student was a: ☐ Freshman ☐ First Year Transfer Student ☐ Sophomore, Junior or Senior

(2) Date of Accident or Injury _____/_____/_____ (3) Date reported to athletic department official _____/_____/_____

(4) Is this condition a(n)? ☐ Acute Accidental Injury ☐ Chronic/Overuse Condition

(5) Name of Sport where injury occurred? _____

(6) Occurred during a: ☐ Game ☐ Scheduled & Supervised Practice ☐ Supervised & approved Training & Conditioning Session

(7) Mechanism of Injury: _____ Body Part: _____ L R

(8) Has the athlete injured the same body part in the past? ☐ Yes ☐ No (If yes, please attach a copy of the pre-participation physical showing athletic clearance)

To any medical care provider, medical care facility, Insurer, government-sponsored health plan or employer: I grant authorization *(while my claim is pending)* of the release of any medical information about me to NAHGA Claim Services and its representatives, EIIA, United States Fire Insurance Company and other persons or groups performing business or legal services relating to my claim. This applies to all information necessary to determine the eligibility of my claim. A copy of this authorization *(one of which will be given to me by NAHGA Claim Services upon my request)* will be valid as this one for a period of 24 months from the date of my signature. I may revoke this authorization by written request to NAHGA Claim Services.

I certify that the above information provided by me in support of this claim is true and correct. I understand that if I knowingly misrepresent or falsify essential information requested by this form I may, upon conviction, be subject to fine or imprisonment.

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.

Insured Student's Signature: _____ Date: _____

Participating Institution's Authorization: _____ Date: _____

FOR PRIVACY POLICY INFORMATION PLEASE GO TO: *www.cfins.com*

IMPORTANT NOTICE!

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Florida Claimants: WARNING: 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.

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to Oklahoma Claimants: 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.

Notice to Pennsylvania Claimants: 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.

Notice to Tennessee and Virginia Claimants: 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.

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

CLAIM FILING PROCEDURES:

1. An Accident must be reported to the Student Insurance Coordinator within 24 hours following the Accident. Accidents incurred during supervised practice or play should be reported to the Athletic Trainer or Athletic Department Official immediately following the injury.
2. If you are insured by an HMO, PPO or similar arrangement, they must be contacted for proper instruction or authorization on covered health care. HMO & PPO Plans must be utilized. If you do not use the facilities or services of the HMO, PPO or similar arrangement, medical benefits may be reduced depending on your plan.
3. The coverage afforded by the Intercollegiate Sports, Accident and Sickness Reimbursement Plans may provide benefits in ***EXCESS*** of any other coverage the student may have. If so, all eligible charges submitted must be accompanied by an Explanation of Benefits (EOB) from the primary insurance carrier(s). The Insurance Statement in Section 2 of this Claim Form must be completed or your claim will be pended and information will be requested from you, delaying your claim processing.
4. Incomplete Claim Forms will result in a processing delay. Allow up to 4 weeks for processing after all information is received.
5. All bills must be itemized insurance bills. If you informed your medical provider of this insurance, they will likely submit the necessary billing and primary explanation of benefits. It is always a good idea to show them your ID card for this coverage or provide them with the name of your school/policy or coverage number and the NAHGA address. (HCFA and UB forms are preferable.)
6. File only one Claim Form per loss (Accident or Sickness). Once the initial Claim Form has been filed, additional information submitted should be identified with the school's name, the student's name, ID# and the initial date of loss.

IMPORTANT INFORMATION:

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- Written notice of a claim must be given within ***180*** days after a covered loss occurs.
- All eligible expenses must be submitted within one year from the date of service.
- Please refer to your plan document at www.eiia.org for specific policy information.

If you have any questions about filing your claim, please contact your school's Student Insurance Coordinator or NAHGA Claim Services at 1-877-497-4980.

PLEASE KEEP A COPY OF THIS CLAIM FORM AND ALL INFORMATION SUBMITTED FOR YOUR RECORDS!