ACCIDENT CLAIM FORM

MAIL TO: CoverGame Insurance - Claims
1055 Westlakes Drive
Berwyn, PA 19312

Questions: Contact 1-908-370-7730

INSTRUCTIONS: SIGNATURE SECTION MUST BE COMPLETED AT BOTTOM OF ALL THREE PAGES

All fields must be completed. ***Failure to complete all sections and fields may result in a delay in processing of a claim.***

This coverage is excess insurance and will pay on a secondary basis to primary coverage. Submit all medical bills to your primary health plan first.

-Part I - Must be completed by Policyholder
-Part II - Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor.
-Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedures codes.
-Attach explanation of benefits, additional bills with record of payment or denial from primary insurance plan.
--For additional instructions about how to file a claim, please send an email to info@egp-inc.com.

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

PART I: POLICYHOLDER REPORT (Signature is required at the end of this section.)

1. Policy Number: US2166929
2. Name of Policyholder: _____
3. Policyholder Address: _____
4. City: _____ State: _____ Zip Code: _____
5. Policyholder Contact: _____ Email: _____ Phone: _____
6. Last name of Claimant: _____ First name of Claimant: _____
7. Social Security Number: _____ Date of Birth: _____
8. Sex: Male ☐ Female ☐
9. Competition league (if applicable): _____ Event Name (if applicable): _____
   Ski Resort or Ski Venue: _____ Race Venue: _____
10. Nature of injury: (**Describe, nature of injury - e.g. broken arm, sprained ankle) Must be a bodily injury due to accident.**

11. Describe how the accident occurred, provide all details.
    Attach a separate sheet, if necessary (include name of sport / activity)

12. Date of Accident: _____ Time of Accident: _____ ___AM ___PM

13. Place of Accident: _____

14. Name and title of person supervising activity: _____
    Was he or she a witness? ___YES ___NO

15. Other witness name: _____ Contact information: _____

_____ _____ _____
Signature of Authorized Policyholder Representative **Title** **Date**

PART II: (To Be Completed by Claimant or Parent/ Guardian, if Claimant is a Minor)

List all medical and dental coverage or plans under which the Claimant is insured:

Name of Insurance Company or Plan	List Type of Coverage	Coverage Policy Number

Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If yes, please provide a copy of the insurance card (front and back).

a. Group Health Plan? ___YES ___NO
   If yes, name of Group Health Plan: _____
b. Individual Health Plan: ___YES ___NO
   If yes, name of HMO or organization: _____
c. Medicare? ___YES ___NO
d. Medicaid? ___YES ___NO

AFFIDAVIT:

I verify that the statement on the 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 the Company to the extent for which the Company would not have been liable. I consent that the Company can provide their services and communicate with me via mobile phone, messages, e-mail and any form of online communications including electronic signatures, provided that these communications comply with privacy regulations.

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 Sirius America Insurance Company, its employees and authorized agents for the purpose of validation and determining benefits payable. I further authorize Sirius America or its agents to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

PAYMENT AUTHORIZATION: (Signature is required at the end of this section)

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, unless paid receipts accompany this form.

_____ _____

Claimant Signature (Parent or guardian, if the claimant is a minor) **Date**

CLAIM FORM FRAUD STATEMENTS: (Signature is required at the end of this section)

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.

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.

ARKANSAS. RHODE ISLAND AND 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.

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 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 and IDAHO: 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.

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.

KANSAS: Any person who, knowing and with intent ,to defraud, presents, causes , to be presented or prepared, with knowledge or belief, that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

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, VIRGINIA, and 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 may include imprisonment, fines or 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, defrauds, 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.

NORTH CAROLINA and OREGON: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

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: 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.

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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Claimant Signature (Parent or guardian, if the claimant is a minor) **Date**