SADLER & COMPANY, INC.

P. O. Box 5866, Columbia, SC 29250-5866 Phone (800) 622-7370 Fax (803) 256-4017

January 1, 2006

TO: NATIONAL FIELD ARCHERY ASSOCIATION - MEMBER CLUBS

RE: 2006 EXCESS ACCIDENT CLAIM FORM

ACCIDENT CLAIMS: When you have an injury to an NFAA MEMBER of your club, please complete one of the enclosed **2006 PROOF OF LOSS** forms. After the form has been completed, and any necessary bills or receipts attached, mail it to **AIG Claim Services, A&H Claims Dept., P O Box 15701, Wilmington, DE 19850-5701.** If you should have any questions about an ACCIDENT CLAIM, please call AIG Claim Services at 1-800-551-0824. (PLEASE NOTE: Do not send the 2006 Proof of Loss form or bills to Sadler & Company as this will delay the processing of the claim.)

Please note that this coverage is Excess/Secondary to any other valid and collectible coverage subject to a $250 deductible. This means if there is other health or accident coverage, all charges must be submitted to them first on a primary basis. If you have other coverage, the other carrier's payment(s) will be used to satisfy our deductible. If you have no other coverage, we will apply the $250 deductible to the charges received until the deductible has been satisfied.

If the "other insurance" is in force under a HMO, PPO, or similar plan, the Insured must follow their rules for obtaining benefits, otherwise benefits under this plan may be reduced and the deductible will be charged.

Please be sure that all blanks are complete, and that both the claimant and the authorized club/shop representative have signed the form. After the claim form has been submitted, if there are additional bills please forward them to **AIG Claim Services**. Make sure that your policy number is on the additional bill(s) and that it is noted that it is an additional bill to a previously reported claim.

Sincerely,

Salinda

SPORTS INSURANCE DIVISION
Email: nfaa@sadlersports.com

American International CompaniesÒ

2006 PROOF OF LOSS - ACCIDENTAL DEATH

National Union Fire Insurance Company of Pittsburgh, Pa.

A&H Claims Department
P. O. Box 15701
Wilmington, DE 19850-5701
800-551-0824/302-761-3700

NAME OF GROUP: **National Field Archery Assoc.**

POLICY NUMBER: **SRG 9104582**

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Beneficiary. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Beneficiary will be required to complete PART B. Be certain that PART C on the reverse side is completed in full and signed by the Beneficiary.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) A Certified Copy of the final death certificate;
(2) Your company's enrollment benefits form and Beneficiary Designation;
(3) Confirmation of employee's Principal Sum and current premium payment;
(4) The Police Report, any Autopsy Report, and any newspaper clippings.
(5) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of trip, destination to and from trip, and confirmation that trip was authorized by the company.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS	ACCIDENTAL DEATH BENEFIT IN FORCE $

EMPLOYEE'S NAME AND ADDRESS	DATE EMPLOYED	DATE OF BIRTH

EFFECTIVE DATE OF COVERAGE	SOCIAL SECURITY NUMBER	DATE OF DEATH	OCCUPATION

TERMINATION DATE OF COVERAGE	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY)	DATE PREMIUM PAID TO

DATE LAST WORKED

STATUS ON DATE LAST WORKED:

☐ ACTIVE ☐ RETIRED ☐ PREMIUM WAIVER FOR DISABILITY ☐ APPROVED LEAVE OF ABSENCE (EXPLAIN) ☐ OTHER

EMPLOYEE WAS: ☐ HOURLY ☐ SALARIED ☐ COMMISSIONED ☐ OTHER (EXPLAIN)

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT

DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER

GROUP POLICYHOLDER/EMPLOYER SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER

GROUP POLICYHOLDER/EMPLOYER	BY (THEIR AUTHORIZED REPRESENTATIVE)

PART B: IMPORTANT TAX INFORMATION

To Be Completed by Beneficiary

Social Security Number/
Tax ID Number

Please Print or Type Name of Beneficiary

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

Be Certain Part C on the Reverse Side is Completed

NATIONAL FIELD ARCHERY ASSOCIATION SRG 9104582

PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, please be certain the authorization below is signed by the beneficiary. The completed and signed claim form along with the Certified Death Certificate, Police Report, Autopsy Report, and any newspaper clippings should be returned to the Employer/Administrator.

NAME OF BENEFICIARY	RELATIONSHIP TO DECEDENT	BENEFICIARY'S DATE OF BIRTH

NOTE: If any designated beneficiary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR)	TIME ☐ A.M. ☐ P.M.	WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER)

WHAT WAS CAUSE OF DEATH?	DATE OF DEATH (MO., DAY, YEAR) ATTACH COPY OF DEATH CERTIFICATE.

WHEN DID SYMPTOMS OF CAUSE OF DEATH FIRST APPEAR?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THE INJURIES CAUSING DEATH.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).

NAME	ADDRESS	AILMENT
NAME	ADDRESS	AILMENT

LIST ALL WITNESSES TO ACCIDENT.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.

NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE
NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

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.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: 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.

SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER	HOME PHONE NUMBER
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