NOTICE

- This claim form MUST be received by the Insurance Company within 90 days of the date of Injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52 weeks after the date of accident.
- When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Please note that your primary carriers payments may not satisfy the deductible under our plan.

CLAIM PROCEDURE

1. Have an Official of the Organization **complete, date** and **sign** PART A.
2. The Injured Person (Insured) — or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian — MUST **complete, date** and **sign** PART B.
3. After PARTS A and B have been completed in full, mail the form to the address shown below **within 90 days** of the date of injury.
4. Send all medical bills to your other health and accident insurance company(s) **first**, if applicable. This can include employee plans, union plans, service contracts, H.M.O. Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment, notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown below.

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1. COMPLETE THIS FORM.
2. ATTACH ALL BILLS.
3. MAIL TO ➔

ACCIDENT CLAIM FORM

PLEASE PRINT OR TYPE

Administered by:

COMMERCIAL TRAVELERS MUTUAL
INSURANCE COMPANY
Attn: Special Risks Division Claims
70 Genesee Street Utica, New York 13502
1-800-756-3702

IF PARTS A and B ARE NOT COMPLETED **IN FULL**, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

PART A - This PART **MUST** be **completed, dated** and **signed** by an official of the Organization.

1. Name of Organization (Policyholder)	2. Policy No.	3. Name of Organization or Team (if different from Policyholder)		
4. Address of Organization (Policyholder)	(Street)	(City)	(State)	(Zip)
5. Name of Injured Person (Insured)	(First)	(Middle)	(Last)	
6. Date of Accident/Injury Mo. Day Year / /	7. Injury Occurred: Practice ❑ Travel ❑ Game ❑ Other ____	8. Type of Sport or Activity:		
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.				
10. Describe the nature of injury—including body part injured Left ❑ Right ❑				
11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ❑ No ❑	12. Name of Supervisor of Activity	13. Was he/she a witness to the accident? Yes ❑ No ❑		
14. Signature of Organization Official X ____	15. Title of Official	16. Area Code/Telephone No. ( )	17. Date signed	

PART B — This PART MUST be completed, dated and signed by the Injured Person - or if the Injured Person is under age 18 or otherwise dependent — by his/her Parent or Guardian.

PRINT HERE— NAME OF PERSON COMPLETING FORM: Check one: Injured Person ❑ Parent ❑ Guardian ❑	NAME OF INSURED PERSON:

Give the following information **about the Injured Person:**

1. Date of Birth Mo. Day Year / /	2. Male ❑ Female ❑	3. Social Security No. / /	4. Area Code/Home Telephone No. ( )

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Address) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident insurance plan(s)? Yes ❑ No ❑
If YES, give the following information:

Name of Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)

8. Name of Father or Male Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

Name of Mother or Female Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

9. If the Injured Person is married, give the following information:

Name of Spouse — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also authorize the Insurance Company checked on the reverse or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service. and such payment shall release the Insurance Company from liability as to amounts so paid

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

X ______________________ Signature (in writing) of Responsible Party

______________________ Print Name

Check one: ❑ Injured Person ❑ Parent ❑ Guardian

Date: ______________

THE BENEFIT PERIOD FOR ELIGIBLE EXPENSES IS 52 WEEKS FROM THE DATE OF ACCIDENT, EXCEPT FOR YOUTH BASEBALL, SOFTBALL AND T-BALL, WHICH HAVE A 156 WEEK BENEFIT PERIOD

AK, CT, DE, HI, IA, ID, IL, IN, MI, MN, MO, MT, MS, NC, ND, NV, SC, SD, UT, WI & WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.

AL, AR, DC, LA, MA, and RI: 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.

AZ: 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.

CA: 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.

CO: 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."

FL: 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.

GA, NE, KS, OR, TX, VT: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud.

KY: 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 commits a fraudulent insurance act, which is a crime.

ME: 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.

MD: 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.

NH: 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.

NJ: Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

OH: 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.

PA: 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.

OK: 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.

TN: 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.

VA, WA: 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 or a denial of insurance benefits.

WV: 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.