UNITED STATES JUDO FEDERATION
FOUNDED 1952

United States Judo Federation Accident Claim Form

Our insurance plan has been designed to provide benefits at a minimal cost for USJF members. This insurance is excess over other insurance you may have and benefits will only be paid for those eligible expenses left unpaid by other insurance.

1. Please type or print clearly. The claim form must be properly completed. "None" or "Not Applicable" should be used when appropriate. The form must be signed by: the injured member, their parent or guardian (if member is a minor), and the club coach. Incomplete or improperly completed forms cannot be processed and will be returned.
2. This form must be completed and mailed to the USJF National Office **within 60 days** of the date of the injury to report the accident. **Failure to do so will void your coverage.**
3. File all bills with your primary family health and accident carrier first. This may include employee plans, military plans, welfare plans, service contracts, and etc. After you have received a notice of payment, notice of denial, or letter stating you have met your deductible from you primary carrier, forward that statement to the USJF National Office.

USJF National Office • P.O. Box 338 • Ontario • Oregon • 97914 • Phone (541) 889-8753 • FAX (541) 889-5836 • FAX2 (413) 502-4983

PART A MEMBER INFORMATION

1. Name of Injured Member (Last, First, MI)	2. Birth Date	3. Sex

4. Address

5. Telephone Home Work	6. Name of Judo Club

7. Membership No.
USJF # ☐ USJI # ☐ USJA #

8. Name & Address of Employer

PART B PARENT/GUARDIAN STATEMENT

1. Name of Living Parent(s) or Guardian(s)	2. Relationship ☐ Father ☐ Mother ☐ Guardian

3. Address of Parent or Guardian

4. Telephone of Parent or Guardian
Home Work

5. Name & Address of Father's/Guardian's Employer

6. Name & Address of Mother's/Guardian's Employer

PART C ACCIDENT INFORMATION

1. Injury Occurred At (Name of Place or Event)	2. Date Of Injury	3. Injury Occurred During ☐ Practice ☐ Tournament ☐ Travel ☐ Camp/Clinic ☐ Other

4. Details On How Injury Occurred	5. What Part Of Body Was Injured

6. At the time of the accident, was the injured person involved in any activity under the jurisdiction of a USJF Coach, Trainer, or Sanctioned Event Official? ☐ YES ☐ NO	7. Name of Coach or Official Were they a witness to the accident? ☐ YES ☐ NO	8. Has a previous claim been filed? ☐ YES ☐ NO

PART D OTHER HEALTH INSURANCE COVERAGE

Give name, address, and policy number of all other Health & Accident Insurance Plans (including those of Parents or Guardians) that may cover this claim.

PART E CERTIFICATION

CERTIFICATION BY USJF COACH I certify that all of the above is correct to the best of my knowledge. I ☐ did ☐ did not witness the accident. Date Signature	CERTIFICATION BY USJF NATIONAL OFFICE I certify that the above claimant was a current member and was covered by USJF insurance at the time of the accident. Date Signature

Previous Editions Of This Form Are Obsolete And Should Not Be Used

IF CLAIM IS FOR A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN THIS FORM

National Union Fire Insurance Co. of Pittsburg, Pa
AIG Claim Services
A&H Claims Department
P. O. Box 15701
Wilmington, DE 19850-5701
800-551-0824/302-661-4176

PROOF OF LOSS

NAME OF GROUP: **United States Judo Federation**

POLICY NUMBER: **SRG 9104534**

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

1.) You must have SECTION A fully completed by a designated official of the Policyholder.
2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.

☐ PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

☐ EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN — DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY

INDICATE THE SPORT (IF APPLICABLE)

DID ACCIDENT OCCUR:

A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER ( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE — DATE

SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE # ( )

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

AUTHORIZATION and ASSIGNMENT OF BENEFITS

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.

I authorize payment of medical benefits to the physician or supplier for service performed. **☐ YES** **☐ NO**

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE — DATE

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.