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 your primary carrier, forward that statement to the USJF National Office.

USJF National Office • P.O. Box 338 • Ontario, OR 97914-0338 • Phone (541) 889-8753 • FAX (541) 889-5836 • Email no@usjf.com

PART A — MEMBER INFORMATION

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

4. Address

5. Telephone Home Work	6. Email

7. Membership No. USJF # ☐ USJI # ☐ USJA #	8. Name of Judo Club

9. Name & Address of Employer

PART B — PARENT/LEGAL GUARDIAN STATEMENT

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

3. Address of Parent or Legal Guardian

4. Telephone of Parent or Legal Guardian Home Work	5. Email

6. Name & Address of Father's/Legal Guardian's Employer

7. Name & Address of Mother's/Legal 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

USJF Form 540, V3.0.0, 210726

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

Claims Filing Instructions

This policy provides excess accident medical coverage for injuries sustained while participating in a covered activity or covered travel as defined by the policy. Medical bills must be submitted to all other valid and collectible insurance plans prior to submitting to this plan for consideration. ***HSR*** will consider benefits according to the terms and conditions of the policy after other available insurance has processed the claim. Please read the following to expedite the claims process.

PART I – POLICYHOLDER'S REPORT

Part I should be completed and signed by a representative of the Policyholder (e.g. coach, official, track/club official, etc.).

PART II – OTHER INSURANCE STATEMENT & PART III – AUTHORIZATION TO PAY BENEIFTS TO PROVIDER

To submit a claim for consideration complete Part II and III, if a minor, the parent/guardian should complete form and submit to ***HSR***. Please note the following:

- Incomplete claim forms are one of the most frequent reasons claim payments are delayed.
- Answer and complete the section regarding "PART II - OTHER INSURANCE STATEMENT", marking either "yes" or "no", and signing the line for authorization. By marking "yes", this will allow ***HSR*** to communicate with the doctors/hospital(s) concerning your claim to expedite the claims process.
- Make a photocopy for your records either mail, email, or fax to the below.
- It is your responsibility to submit completed claim form to ***HSR***.

CLAIMS CONSIDERATION

1. To streamline the process, please notify all doctors/hospitals of all available health insurance, as well as, the excess accident medical coverage. Provide them ***PAYOR # 65449 for HSR billing.*** This will allow the medical provider to forward the itemized bills directly to ***HSR***.
2. If you have already received treatment related to injury and did not know about this coverage, then please send all statements/itemized bills to ***HSR*** at the address shown below.
    - Note, an itemized bill should include the name of the doctor/hospital, their complete mailing address, telephone number, the date of service/treatment, the type of service/treatment and the specific itemized charges incurred. **Balance Due** statements do not include the required information to consider charges.
3. In addition to the itemized bill(s) copies of the corresponding Explanation of Benefit(s) from other valid and collectible insurance showing their claim consideration are required to consider charges.

Health Special Risk, Inc.
4100 Medical Parkway, Suite 200
Carrollton, TX 75007
Customer Service at (800) 328-1114
Fax: (972) 512-5820
Email: claims@hsri.com
Available: Monday – Friday 8:00 am to 6:00 pm Central

First Health MultiPlan

HSR Health Special Risk, Inc.

Policy Name: _____

Policy Number: _____

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO *HSR*
E-mail : claims@hsri.com

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (800) 328-1114

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)	2. Social Security Number	3. Gender ☐M ☐F	4. Date of Birth	5. E-Mail

6. Address of Injured Person and Best Contact Phone Number (Include Area Code)

7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)

8. Date and Time of Accident	9. Place where Accident Occurred	10. The injured person was a: ☐ Participant ☐ Staff Member ☐ Guest ☐ Volunteer

Dental Claims	11. Indicate which Teeth were Involved in the Accident	12. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) **Did Injury Result in Death? ☐YES ☐NO**

14. Describe How Accident Occurred – Give All Possible Details

15. Did Accident Occur (Check Yes or No for Each of the Following):

A.	During a policyholder programmed, sponsored & supervised, or sanctioned activity?	☐YES	☐NO	
B.	On activity premises?	☐YES	☐NO	
C.	While on the job (if applicable)?	☐YES	☐NO	
D.	While traveling directly and uninterruptedly to or from home and policyholder premises?	☐YES	☐NO	
E.	During intercollegiate/scholastic athletic practice? ☐YES ☐NO or competition?	☐YES	☐NO	

16. Name of Event or Activity	17. Name and Title of Supervisor

18. Name of Policyholder

20. Signature of Policyholder Representative	21. Title of Policyholder Representative	22. Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐YES ☐NO

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	DATE

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. **(if not signed, submit proof of payment)**

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

FRAUD STATEMENTS

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

Alaska and 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, 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.

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, Louisiana, Maryland, West Virginia &Rhode Island : Warning: 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 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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: 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: 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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
   a) In any written statement;
   b) In the filing of a claim; or
   c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

Maine: 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: 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, as provided in RSA 638:20.

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

New Mexico and 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.

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.

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: 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.

Oregon: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.