USA VOLLEYBALL
MEDICAL CLAIM FORM
2018-2019 Season

SEND THIS FORM TO:
American Specialty Insurance & Risk Services, Inc.
7609 W. Jefferson Blvd.
Suite 150
Ft. Wayne, IN 46804
Customer Service Number: 800-245-2744
Email: claimsPA@americanspecialty.com

This form should be completed whenever a medical claim results from an injury incurred at USA Volleyball sanctioned events.

PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY

NAME (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)

TELEPHONE NUMBER ( )	OCCUPATION
USA VOLLEYBALL PARTICIPANT #:	DATE & TIME OF ACCIDENT: _____/_____/_____ _____ ___ AM ___ PM

INJURED PARTY WAS:
☐ PARTICIPANT ☐ COACH ☐ OFFICIAL ☐ VOLUNTEER ☐ OTHER: _____

IF PARTICIPANT, MEMBERSHIP TYPE:
☐ JUNIOR MEMBER ☐ ADULT MEMBER ☐ NATIONAL OR HIGH PERFORMANCE TEAM MEMBER

REGIONAL ASSOCIATION NAME:	COACHES NAME: PHONE #: ( )

NATURE OF INJURY

FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT:

_____

B. DESCRIBE WHERE ACCIDENT HAPPENED:

_____

C. DESCRIBE HOW ACCIDENT HAPPENED:

_____

D. DID THE ACCIDENT OCCUR DURING:

☐ COMPETITION ☐ PRACTICE ☐ TRAVELING TO/FROM ☐ OTHER: _____

E. WITNESS NAME: _____ PHONE #: _____

IF INJURED PARTY IS A MINOR:

PARENT/GUARDIAN NAME: _____ HOME PHONE #:_____

EMPLOYER NAME: _____ WORK PHONE #:_____

IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? ☐ YES ☐ NO

IF YES, NAME OF INSURANCE COMPANY	POLICY NUMBER

ADDRESS (Street) (City) (State) (Zip Code)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.

NAME OF PATIENT	SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)	DATE

I certify that the foregoing information is true and correct.	SIGNATURE	DATE

The completion of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.