USA Wrestling Notice of Injury

In case of injury, the injured party, parent, or coach of the injured party should complete this form and mail it immediately to *USA Wrestling, 6155 Lehman Drive, Colorado Springs, CO 80918.* Call 1-719-598-8181 for any questions concerning your claim. This secondary sports accident insurance is a benefit of your membership in USAW. Coverage is provided via an outside carrier. A deductible applies in addition to other conditions of the policy. Instructions and details regarding coverage and the deductible will be mailed once this form is received and processed. This Notice of Injury form must be complete or it will be returned to the injured party.

Name of injured party _____ Birth Date _____ USA Wrestling Card # _____

Mailing address _____ City _____ State _____ Zip _____

Phone number ( ) _____ If injured party is a Minor, name of parent or guardian _____

E-mail _____

Injured party is a: ❑ Competitor ❑ Coach ❑ Official ❑ Other (describe) _____

Date of Accident _____

Social Security # _____-_____-_____

Where accident took place (check one)

❑ At a club practice ❑ At an event

Name of club _____ Name of event _____

City, State of Club _____ City, State of Event _____

Other (describe) _____

Describe the nature of the injury as best you can; naming body parts affected, etc. _____

Describe how injury happened; i.e. what move was being attempted, etc. _____

Primary health insurance company _____ Phone number ( ) _____

Address _____ City _____ State _____ Zip _____

Report submitted by: _____
Signature

Complete the following, if known:

Will the injured be off for more than 1 (one) week? ❑ Yes ❑ No Name of Doctor _____

Hospital referred to: _____ Address _____ City _____ State _____ Zip _____

Falsification of information on this report will void your benefits under USA Wrestling's Sports Accident Insurance Program

Please make sure that the form is filled out completely and mail it to:

USA Wrestling
Notice of Injury
6155 Lehman Drive
Colorado Springs, CO 80918

STATE USE ONLY

Verified by State ❑ Yes ❑ No

Date: _____

NATIONAL OFFICE USE ONLY

Club Verified	❑ Yes	❑ No
Event Sanction Verified	❑ Yes	❑ No
Membership Verified	❑ Yes	❑ No

MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP.
CN 98000
PENNSAUKEN, NJ 08110
(800) 257-6250

NOTIFICATION OF INJURY

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

FOR OFFICE USE ONLY

Policy Number
Reference Number
Claim Number

SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM.

PART I – TO BE COMPLETED BY COACH, MANAGER OR PROPERLY DELEGATED AUTHORITY

1. Name of School/Organization				2. Name of Team	
3. Name of Injured Individual	Last	First	Middle Initial	4. Social Security No.	5. Birthdate
8. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)					
9. Describe how accident occurred. (Give all possible details.) **MUST BE A BODILY INJURY DUE TO ACCIDENT.**					

10. Did Accident Occur:	Yes	No	11. a) Date of Accident	12. Name of Activity/Sport
a) While claimant was supervised	❑	❑		
b) During sponsored activity	❑	❑		
c) During programmed hours	❑	❑	b) Time	12A. (Check One) ❑ Coach ❑ Manager ❑ Player/Member
d) On activity premises	❑	❑		
e) While traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group.	❑	❑	c) Place	13. Name and Title of Supervisor

14. Signature of Coach, Manager or Delegated Authority	15. Title	16. Date

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL

PART II – TO BE COMPLETED BY CLAIMANT – OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian or Claimant (if adult)	2. Social Security No.	
3. Name of Mother or Guardian or Spouse (if adult)	4. Social Security No.	
5. Address of Parents or Guardian/or Claimant	5A. Telephone Number	
6A. Father or Guardian's or Claimant's Insurance Company(ies)	6B. Mother or Guardian's or Spouse's Insurance Company(ies)	Check One: ❑ Individual ❑ Group
7A. Name, Address and Phone Number of Father or Guardian's or Claimant's Employer	7B. Name, Address and Phone Number of Mother or Guardian's or Spouse's Employer	

8. List other insurance policies under which claimant is insured

Company	Policy No.	
1.	1A.	❑ Individual ❑ Group
2.	2A.	❑ Individual ❑ Group

Affidavit: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent or Guardian or Claimant _____ Date _____

Authorization: I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

_____ _____
Signature of Claimant (Parent or Guardian if Insured is a minor) Date

SR

Accident insurance coverage is available to protect insureds against accidental injury or death occurring while the policy is in force. **Maksin Management Corp** is the administrator of this coverage.

Benefits are provided for covered expenses incurred within a certain time period* after the date of the accident.

Full Excess means that benefits are payable for covered expenses that are in excess of other valid and collectible insurance.

You must submit your claim to your insurance company first. When you receive their Explanation of Benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy.

Primary Excess means that benefits are payable for the first $100 of eligible covered expenses, without regard to other insurance. Additional eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance.

Submit your claim to Maksin Management Corp first. We will pay the first $100 of eligible covered expenses. You must then submit your claim to your insurance company. When you receive their Explanation of Benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits, otherwise our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.

CLAIM INSTRUCTIONS

In case of accident, notify the school immediately.

1. Treatment must commence within 90 days from the date of the injury.
2. Send this claim form to us within 90 days from the date of the injury. DO NOT leave this form with the school, organization, coach, hospital, physician, etc.
3. Do not leave any blank spaces or write "N/A" in a space. If either parent is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you do not have insurance, please state "no insurance". If you are employed, please provide us with a statement from your employer that the claimant has no insurance. (Our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage).
4. If claimant is insured under Medicaid, please indicate this.
5. Please attach itemized bills to the claim form, or mail them as soon as possible. An itemized bill includes treatment rendered, the dates of the treatment, physician's or hospital's name, address and tax I.D. number, and diagnosis code. Balance Due bills are **not** acceptable.
6. If you have other insurance, your insurance company will send you an Explanation of Benefits (EOB) which shows what they paid or denied. We need a copy of the EOB for each itemized bill submitted to us.
7. Or, your provider(s) may forward the itemized bills to us along with the corresponding EOBs.
8. Our address is **Maksin Management Corp, CN 98000, Pennsauken, NJ 08110**. Customer Service can be reached on **800-257-6250**. We will be happy to assist you.
9. Benefits are paid to the providers of service unless we receive paid receipts.

•All policies have a limited benefit period. The insured will be covered for a minimum of one year from the date of the accident. For the exact benefit period of the claim, contact Maksin Management or your school/organization.