Q2 SPORTS INSURANCE

CLAIM REPORTING PROCEDURES

All claims regardless of severity or location should be reported directly to **American Claims Management (ACM).** Losses can be reported 24 hours a day/seven days a week, at:

- **Email:** NewLosses@acmclaims.com or
- **Telephone:** 888-799-2919

Claims correspondence can be sent to ACM's Claim Department Mailing address:

ACM Claims
P.O. Box 9060
Carlsbad, CA 92018-9060

IMPORTANT

- Please include your policy number and insured name, on all correspondence.
- If you have any video of the incident, please be sure to preserve the ORIGINAL and make a copy to provide to ACM.
- **All Claims or Incidents must be reported within 90 days.**

IMPORTANT NOTICE:
This insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL OR EMAIL TO ACM

E-mail : newlosses@acmclaims.com

American Claims Management (ACM)

ACM Claims
P.O. Box 9060
Carlsbad, CA. 92018-9060
Phone: 1 (888) 799-2919
Email: Newlosses@acmclaims.com

SPORTS INSURANCE

Name of Policyholder: _____

Accident Medical Policy Number: _____

PART I - POLICYHOLDER & INSURED

1. Name of Policy holder/Promoter/Team/League		2. Policy Number	
3. Claimant - Last Name, First Name		4. Claimant Social Security Number	
5. Mailing Address where Insurance Info/Requests should be mailed		6. City, State, Zip	
7. Birthdate	8. Male ❑ Female ❑	9. Phone	10. Email

INJURY - Please Complete this Section to report an Injury

11. Date of Injury	12. Time & Address where occurred?	13. Part of body injured
14. How did injury occur (description of incident)?		15. Date of first medical treatment

16. Type of Sport (if applicable): 17. Sport Designation: ❑Practice ❑ Game ❑Event ❑ Other

18. Action Taken: ❑ Released to Parent ❑ Ambulance Transport ❑ Referred to Hospital/Clinic ❑ Own Accord (Adult) ❑ Other _____

19.Claimant Designation: ❑ Coach/Manager ❑ Volunteer ❑ Participant ❑ Umpire/Referee ❑ Other

20.Was the claimant supervised when injured? Yes ❑ No ❑ 21.Was injury during travel to or from scheduled activity in a supervised group? Yes ❑ No ❑

22.Signature of Policyholder: Date

PART II – PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)

1. Father/Guardian Name	9.Mother/Guardian Name
2.Home Address (Street, City, State, Zip)	10.Home Address (Street, City, State, Zip)
3.Telephone 4.Email	11. Telephone 12. Email
5. Employer	13. Employer
6.Father's Employer Address (Street, City, State, Zip)	14.Mother's Employer Address (Street, City, State, Zip)
7. Business Phone	15.Business Phone
8. Employer Medical Insurance Policy (8a) Policy Number: _____ (8b) Is Claimant covered under that policy? Yes ❑ No ❑ (8c) Is Claimant covered under that policy? Yes ❑ No ❑	16.Employer Medical Insurance Policy Address:

PART III – INSURANCE VERIFICATION

Is Claimant covered by any other insurance policy (other than this policy), either as a dependent, group, individual, automobile medical or liability? Yes ❑ No ❑

If yes, Policy Number: _____ Name of Insurance Carrier: _____

Address of Insurance Carrier: _____ _____

Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.

I hereby authorize any hospital, policyholder, physician, employer, or other person who has attended or examined the Claimant to disclose when requested to do so, any information to ACM Claims or POLICYHOLDER with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A copy of this authorization shall be considered as valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to

X _____ _____

Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

X _____ _____

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.