Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM & BILLS TO:

NAHGA Claim Services
PO Box 189
Bridgton, Maine 04009
(800) 952-4320
(207) 647-4569 Fax

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.

If this form is not completed in FULL, this claim can not be processed and will be returned.

PART 1: POLICYHOLDER & INSURED

(1) School/Organization/Group Name	(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

INJURY - Please Complete this Section to report an Injury

(10) Date of Injury	(11) Time & Address where occurred?	(13) Part of body injured
(12) How did injury occur (description of incident)?		(13) Date of first medical treament
(14) Type of Sport (if applicable)	(15) Sport Designation: Practice ❑ Game ❑ Auto Race ❑ Other ❑ _____	

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

(17) Was the claimant supervised when injured? Yes ❑ No ❑	(18) Was injury during travel to or from scheduled activity in a supervised group? Yes ❑ No ❑
(19) Signature of Supervisor/Official (if applicable):	Date

PART 2: PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)

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

PART 3: 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, please list name of insurance carrier: _____

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

PART 4: AUTHORIZATION

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Student to disclose when reqeusted to do so, any information to NAHGA CLAIM SERVICES 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 photostatic copy of this authorization shall be considered as effective and 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 defraud an insurance company.

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 _____ _____

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

V.04.08

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.