A-G ADMINISTRATORS, LLC
P.O. Box 979
Valley Forge, PA 19482
P: 610.933.0800 | F: 610.935.2860
www.agadministrators.com

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits to:
claims@agadm.com
For questions, please contact A-G Administrators.

USA VOLLEYBALL MEDICAL CLAIM FORM

This form should be completed whenever claim results from an injury incurred at USA Volleyball sanctioned events.
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

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:**

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:

PARTENT/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 A-G Administrators, LLC, 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.

USA VOLLEYBALL
MEDICAL CLAIM FILING INSTRUCTIONS

1. DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA VOLLEYBALL.
2. Make sure the injury has been reported to your Regional Volleyball Association.
3. Complete claim form in full. Use an additional sheet if necessary.
4. Either notify medical providers of excess coverage for services related to injury by providing the below mentioned contact information or attach itemized physician, hospital or other providers' standard insurance billing forms: CMS-1500 from physician or UB-04 from Hospital; these forms must show the following:
    - Patients Name
    - Condition/Diagnosis
    - Type of Treatment
    - Date expense incurred
    - Charges
5. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Armed Forces or other coverage. If you wish for payment to be made to you, then you must provide proof of payment from the provider.
6. To expedite proper processing, submit form complete in full along with the above documents to the following address:

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IMPORTANT CLAIM NOTICE

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information 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 or Louisiana: 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.

Delaware: 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: 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.

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

Indiana: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information, commits a felony.

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 information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

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: 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 CIVIL FINES AND CRIMINAL 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. (PURSUANT TO 11 NYC RR86)

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.

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.

Puerto Rico: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

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.

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

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

SIGNATURE OF INJURED PERSON *(parent/guardian if a minor)*

DATE

SPORT ACCIDENT EXCESS MEDICAL INSURANCE COVERAGE

The Sport Accident Excess Medical insurance program provides participant accident coverage for loss resulting directly from members competing in an approved or sanctioned event. Coverage does not include loss from pre-existing conditions or competing in non-sanctioned events. The coverage extends from the start, through the completion of the event, including direct designated group travel to and from the event.

The Accident Medical policy provides up to $25,000 of excess accident medical coverage for expenses incurred within 52 weeks of the date of the accident. Written proof of loss by the Insured is required within 90 days or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity. The policy provides coverage against loss in excess of coverage provided under other valid and collectible medical insurance and is subject to a $250 per claim deductible. If no other collectible medical insurance is available, the loss is subject to a $1,000 deductible.

If injury to the member athlete requires treatment by a legally qualified physician or confinement in a legally constituted hospital, or employment of a trained nurse, x-ray, or ambulance services, and if the first expense of such treatment is incurred within 90 days of the date of the accident, the insurance company will pay the usual and customary expense incurred up to $25,000, subject to the appropriate deductible and any other collectible insurance.

DEFINITION OF PARTICIPANT

All registered athletes, coaches, trainers, volunteers, committee members, and officials while functioning on behalf of and/or while participating in a covered event sanctioned or approved by USA Volleyball.

DESCRIPTION OF ACTIVITY

Participating in regularly scheduled volleyball competitions/events sponsored, sanctioned and supervised by the policyholder; Suring practice sessions for such competitions/events; During pre-event and post event activities which include, but are not limited to award banquets, award ceremonies and clinics that occur within one day (24 hours) of the covered activity;

Coverage is also included for non-sanctioned volleyball related activities for certified officials who meet extended coverage criteria.

SPORT ACCIDENT EXCESS MEDICAL INSURANCE COVERAGE, CONT.

ACKNOWLEDGEMENT WAIVER AND RELEASE FROM LIABILITY

As with most sports activities, a signed "Acknowledgement Waiver and Releasse from Liability" (AWRL) form is required from all participants and from parents or guardians in the case of minors. This requirement exists in virtually every sport. It serves to document that the participants or parents of participating minors have acknowledged the inherent risk and danger associated with participating in sporting events. It is intended to serve as "appreciable warning" of these risks and the participants by signing the waiver, are giving their informed consent to the acceptance of those risks. It is important to remember that a signed waiver DOES NOT reduce the need for insurance or effective safety practices. A signed waiver is USAV's "first line of defense" against a cause of action for negligence and is a very effective risk management tool. The Regional Commissioner and others working under the direction of the Region must make every effort to conduct an event with safety as the number one concern.

CLAIMS ADMINISTRATION

Insurance Providers:

Sport Accident Insurance
A-G Administrators, LLC
P.O. Box 979, Valley Forge, PA 19482
Phone: 610-933-0800 • Fax: 610-935-2860
www.agadministrators.com
E-Mail: claims@agadm.com

Broker/Risk Management
EPIC
2727 Paces Ferry Road, Bldg. 2 - Suite 1500, Atlanta, GA 30339
Phone: 678-324-3300 • Fax: 678-324-3303
E-Mail: sport@epicbrokers.com