III. CLAIMS ADMINISTRATION

EPIC Entertainment & Sports
2727 Paces Ferry Road
Building Two, Suite 1500
Atlanta, GA 30339
Phone: 678-324-3300
Fax: 678-324-3303

Insurance Providers:

General Liability Insurance:
Arch Insurance Company
American Specialty Insurance & Risk Services, Inc.
7609 W. Jefferson Blvd., Suite 150
Ft. Wayne, IN 46804-4133
Direct Phone: 260-755-7275
Main Phone: 260-969-5203
Fax: 260-969-4729
Claims Representative: Jeff Jacobson
Assistant Vice President, Claims Management Services
E-Mail: JJacobson@americanspecialty.com

Participant Accident Insurance:
QBE Insurance Corporation
A-G Administrators, LLC
P.O. Box 21013
Eagan, MN 55121
Phone: 610-933-0800
Fax: 610-935-2860
Email: claims@agadm.com

Broker/Risk Management:
EPIC Entertainment & Sports
2727 Paces Ferry Road
Building Two, Suite 1500
Atlanta, GA 30339
Phone: 678-324-3300
Fax: 678-324-3303
Email: sports@epicbrokers.com

USA VOLLEYBALL CLAIMS ADMINISTRATION
TABLE OF CONTENTS

GENERAL LIABILITY

A. NOTICE OF INCIDENT / INCIDENT REPORTING INSTRUCTIONS

Under the USAV General Liability policy, the Named Insureds are required to provide notice to the insurance carrier of any incidents which may result in a claim.

To ensure compliance with this requirement, Club/Tournament Directors, Coaches, Officials or other USAV representatives are required to submit notice of ALL INCIDENTS that result in bodily injury or property damage at a USAV/RVA Sanctioned or Approved Event.

An official USA Volleyball **Incident Report Form** (see following pages) should be completed and submitted by email to IncidentReports@usav.org as soon as possible following the incident. Incident Report Forms can be found on each Region's website.

If the official USA Volleyball Incident Report Form is NOT available at the time of the incident, the following information should be obtained and forwarded to the appropriate RVA office as soon as possible.

1. Name, address and phone numbers of all individuals who were involved, including any injured persons and witnesses.
2. The name of the Region in which the incident occurred, including the Name of the Club involved and the Name of the Event/Tournament (if applicable) or Type of Event (as applicable).
3. A complete description of the facts pertaining to the incident (including what happened, when, where, etc.). Be sure to include information obtained from the involved parties and any witnesses, including officials or volunteers. If any bodily injury occurred, please be sure to indicate if any first aid or emergency medical transport was required in response.
4. Include any other information that may be helpful with handling of any potential claim.
5. Be sure to include the name and contact information of the person submitting notice of the incident.

NOTE: For any incidents initially reported without using the official USA Volleyball Incident Report Form, the RVA office should send a blank Incident Report Form to the club or event for completion (to ensure consistent collection of sanctioned event incident details).

B. NOTICE OF CLAIMS/LAWSUITS

All Named Insureds (including USA Volleyball, its RVAs, Tournament Directors, Club Directors, Coaches, Officials, etc.) under the USAV General Liability policy should **notify EPIC immediately** by email, fax or phone upon receipt of the following related to any Sanctioned or Approved Event:

1. Receipt of a claim/legal papers, such as notice of claim, letter of representation from an attorney, demand letter, a summons and complaint or other official notice of a claim or lawsuit, etc.
2. Property damage in excess of $10,000.

EPIC will forward the information to American Specialty (the General Liability carrier) for review and consideration.

C. COOPERATION IN THE INVESTIGATION OF INCIDENTS AND THE DEFENSE AND HANDLING OF CLAIMS

After an **Incident Report Form** has been submitted, American Specialty (the General Liability carrier) will review the incident for potential liability triggering defense and coverage under the General Liability policy. The General Liability carrier will often conduct a preliminary investigation, talk with the injured party, any witnesses, the club/tournament director, etc.

The Named Insureds under the USAV General Liability policy are required to cooperate with the insurance carrier in its investigation of the incident and the handling of any subsequent liability claims.

Dependent upon the result of American Specialty's initial review:

- The Claims Representative for American Specialty may log the incident as "received for notice only" and no further action will be taken unless a subsequent claim is filed.
- Assign a Claims Representative to oversee the management and administration of the claim.
- Respond to relevant parties, as appropriate, if an actual claim is anticipated or received.
- May engage outside counsel to assist with the defense and handling of the claim.
- Establish a claim reserve, as appropriate.

Once a formal General Liability claim has been opened, any additional claims documentation or communications received by USA Volleyball or any other Named Insureds related to the claim should be submitted to the Claims Representative at American Specialty:

American Specialty Insurance & Risk Services, Inc.
Claims Representative: Jeff Jacobson
Phone: 800-245-2744 or 260-755-7275
E-Mail: JJacobson@americanspecialty.com

D. CLAIMS FOLLOW-UP

1. USA Volleyball and its Legal Counsel will receive updates regarding the status of General Liability claims on an annual basis (or as otherwise requested).

2. Any questions or concerns regarding the General Liability claims process or the handling of a specific claim may also be directed to Jennifer Rains at Jennifer.Rains@EPICbrokers.com.

PARTICIPANT ACCIDENT COVERAGE

A. MEDICAL CLAIM FORM

As soon as possible, but not later than 90 days from the date of the injury, the injured member must complete in its entirety and sign the MEDICAL CLAIM FORM and forward the form to A-G Administrators. The form is available on the Forms and Information page linked below:

www.teamusa.org/usa-volleyball/membership/forms-and-information.

Medical claim forms should be completed by the injured party and submitted directly to A-G Administrators (due to privacy reasons).

A-G Administrators, LLC
P.O. Box 21013
Eagan, MN 55121
Claims Fax Number: 610-935-2860
Customer Service Number: 610-933-0800
Email: claims@agadm.com

B. CLAIMS FOLLOW-UP

EPIC will receive payment updates, as well as claims status information, on medical claims from the insurance carrier on a periodic basis.

Any additional documentation pertaining to Participant Accident claims received by USA Volleyball, the Region or Club, shall be emailed or mailed to A-G Administrators. In addition, any phone calls concerning these claims shall be directly communicated to A-G Administrators.

Any questions regarding the group Participant Accident claim process or concerns regarding the insurance carrier's service may be directed to Sean Lankie at EPIC.

INCIDENT REPORT FORM

An Incident Report Form needs to be completed **every** time a "bodily injury" or "property damage" incident occurs during a USAV Sanctioned or Approved Event. Tournament Directors, Club Directors and Coaches should be made aware of the importance of completing and submitting these forms whenever a bodily injury or property damage incident occurs.

Documenting the facts surrounding any incidents will help with the defense and handling of claims and reduce the likelihood of fraudulent claims being paid (which will help keep USAV's insurance costs as low as possible). If an Incident Report Form cannot be matched to a claim, it will be more difficult for the insurance carrier to validate the claim.

Tournament Directors, Club Directors and Coaches should have a supply of these Incident Reports Forms with them at each practice or other sanctioned event.

Should you have any questions concerning the General Liability claims reporting, please contact:

General Liability Claims:
Jeff Jacobson at American Specialty
260-755-7275
JJacobson@americanspecialty.com

PARTICIPANT ACCIDENT MEDICAL CLAIM FORM

A Medical Claim Form should be provided to participants (or a parent/legal guardian in the case of a minor) who sustain an injury while practicing for, or participating in, any Sanctioned or Approved Event. Tournament Directors, Club Directors or Coaches should keep a supply of these forms on hand at each practice or event. The Medical Claim Form is to be completed by the injured participant (or a parent/legal guardian in the case of a minor) and sent directly to **A-G Administrators** (the claims administrator for the USAV Participant Accident program).

Upon receipt of a Medical Claim Form, A-G Administrators will pair it with the Incident Report Form submitted by the Region to verify that the injury was sustained at a covered event. A-G Administrators will then contact the injured participant directly (usually by mail) if any additional documentation is needed. Claims processing takes a minimum of two weeks after receipt of claim documents.

Should you have any questions concerning the Participant Accident claims handling, please contact:

Participant Accident-Excess Medical Claims:
A-G Administrators Claims Department:
610-933-0800
claims@agadm.com

USA VOLLEYBALL
INCIDENT REPORT FORM
INJURY OR PROPERTY DAMAGE

Submit this form to:

SUBMIT THIS FORM TO YOUR REGIONAL VOLLEYBALL OFFICE (ADDRESS ABOVE)

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name **First** **Middle**

Telephone Number ( ) ☐ **Single** ☐ **Married**

Address

Social Security Number _____ _____ _____

City _____ **State**_____ **Zip**_____

Age_____ **D.O.B** _____ ____ _____ ☐ **Male** ☐ **Female**

Employer and Address _____

_____

Date of Incident _____ **Time of Incident** _____**AM/PM**

Team Name: _____

Region: _____

USAV Membership #: _____

Does the injured person have other medical insurance? ☐ **Yes** ☐ **No**
If yes, please provide name of company and policy #:

_____

INJURED PERSON: ☐ Participant ☐ Official ☐ Coach
☐ Spectator ☐ Volunteer ☐ Other: _____

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name **First** **Middle**

Telephone Number ( )

Address City State **Zip**

INCIDENT INFORMATION

BODY PART INJURED

☐ Ankle (L/R) ☐ Shoulder (L/R) ☐ Back
☐ Knee (L/R) ☐ Wrist (L/R) ☐ Neck
☐ Nose ☐ Finger ☐ Internal
☐ Head ☐ Eye (L/R) ☐ No Injury
☐ Tooth ☐ Ear (L/R) ☐ Other

If Ankle Injury, was ankle
☐ Taped ☐ Supported
☐ Unsupported
Shoes: ☐ Yes ☐ No

If Knee Injury, was knee:
☐ Braced ☐ Supported
☐ Unsupported
Knee Pads: ☐ Yes ☐ No

INCIDENT

☐ Collision (participant/spectator)
☐ Collision (with object)
☐ Collision (participant/participant)
☐ Collision (spectator/spectator)
☐ Struck by falling/flying object
☐ Caught in, on, between
☐ Animal/insect bite/sting
☐ Slip/Fall
☐ Overexertion
☐ Assault/Sexual
☐ Assault/Non-Sexual
☐ **Property Damage**

COURT SURFACE

☐ Concrete ☐ Asphalt
☐ Grass ☐ Sand
☐ Wood ☐ Sport Court

If sport court, what is under-lying surface?
☐ Wood
☐ Concrete ☐ Asphalt

CLASSIFICATION

☐ Non-injury
☐ Minor injury or illness
☐ Serious injury or illness

INCIDENT LOCATION

☐ Before Competition/Event
☐ During Competition/Event
☐ After Competition/Event☐

☐ Competition area
☐ Concession area
☐ Parking lot
☐ Admission area
☐ Restrooms/locker rooms
☐ Off property
☐ Bleachers/stands

PRIMARY INJURY

☐ Allergy ☐ Dislocation
☐ Amputation ☐ Nausea
☐ Foreign Body ☐ Burn
☐ Laceration ☐ Fracture
☐ Heat Exhaustion ☐ Pain
☐ Hypertension ☐ Cardiac
☐ Cold Injury ☐ Contusion
☐ Electrical Shock ☐ Seizures
☐ Strain/Sprain ☐ Concussion
☐ Abrasion ☐ Sting/bite
☐ Illness ☐ Death

DISPOSITION

No care given:
☐ Patient refused
☐ Not needed
Released:
☐ To parent
☐ To personal vehicle

Referral
☐ To doctor
☐ To hospital/clinic

EMS transport:
☐ Trainer recommended
☐ Patient/parent quested

Describe how the injury or property damage occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

Name	Address	Telephone Number
1.		( )
2.		( )

Tournament Director, Club Director, Coach and/or USA Volleyball Official completing this form:

Name: _____ **Signature:** _____

Title: _____ **Date:** _____ **Phone #:** (_____)_____

Event Name: _____

Event Location:_____

Sanctioning Region:_____ **Region Signature:**_____

A-G ADMINISTRATORS, LLC
P.O. Box 21013
Eagan, MN 55121
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)*

EMAIL ADDRESS:	**TELEPHONE#:**	**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:

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 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

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:

A-G ADMINISTRATORS, LLC
P.O. Box 21013
Eagan, MN 55121
P: 610.933.0800 | F: 610.935.2860
www.agadministrators.com
claims@agadm.com

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