



1. PLEASE FULLY COMPLETE THIS FORM
 2. ATTACH ITEMIZED BILLS
 3. MAIL TO HSR
 E-Mail: gisclaims@hsri.com

HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 Phone: (972) 512-5600 Fax: (972) 512-5820
 Toll Free (866) 345-0973



POLICY NUMBER:
 9906-5288 Ded \$-0-

FOR HSR USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART I – POLICYHOLDER’S REPORT

1. Claimant’s Name (Injured Person)		2. Social Security Number - -		3. Gender _M _F		4. Birthday _ / _ / _		5. E-Mail	
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)									
7. If Applicable, Parent’s Name, Address, and Best Contact Phone Number (Include Area Code)									
8. Date and Time of Accident			9. Place where Accident Occurred			10. The Injured Person was a: <input checked="" type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer			
Dental Claims Only	11. Indicate which Teeth were Involved in the Accident			12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial					
13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)							Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO		
14. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident									
15. Did Accident Occur (Check Yes or No for Each of the Following):									
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?							<input type="checkbox"/> YES <input type="checkbox"/> NO		
B. On activity premises?							<input type="checkbox"/> YES <input type="checkbox"/> NO		
C. While traveling directly and uninterruptedly to or from home and policyholder premises?							<input type="checkbox"/> YES <input type="checkbox"/> NO		
D. During intercollegiate/scholastic athletic practice? <input type="checkbox"/> YES <input type="checkbox"/> NO or competition?							<input type="checkbox"/> YES <input type="checkbox"/> NO		
16. Name of Event or Activity					17. Name and Title of Supervisor				
18. Name of Policyholder Mid-State Youth Football & Cheerleading				19. Address of Policyholder (Address, City, State, Zip)					
20. Signature of Insurance Coordinator					21. Title of Insurance Coordinator			22. Date	

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES NO

If Yes: Name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
------------------------------------	---------	------

PART III - AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

FRAUD STATEMENTS

GENERAL: 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.

ALASKA, ARKANSAS, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

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.

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 RESIDENTS: 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.

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.

MARYLAND: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

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.

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.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

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.

VIRGINIA: Any person who, with the 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 may have violated state law.

GAGLIARDI INSURANCE SERVICES, INC.

284 Digital Drive, Morgan Hill, CA 95037 800-995-9768 Fax 408-414-8199

IMPORTANT INSTRUCTIONS

HOW TO FILE YOUR MEDICAL CLAIM

1. You have been provided with claim forms that are pre-filled with some of the important information that is needed to process your claim efficiently. Please use this form only.
2. Section I must be filled out completely.
3. Section II is to be completed, signed, and dated by the claimant or parent/guardian of the claimant.
4. Include all itemized bills for related medical expenses being claimed. These bills must show the patients name, condition being treated (diagnosis), type of treatment received, date the expense(s) was/were incurred.
5. A deductible will apply to each claim.
6. A League Representative or Insurance Coordinator **must** sign Claim Form.

NOTE:

This coverage is in excess of all other group medical coverage. Please complete in full the attached **Other Insurance Inquiry** and provide copies of the other insurance's **Explanation of Benefits** for each corresponding **Itemized Bill**. Failure to provide this form, completed in its entirety, will delay claim processing.

Mail **FULLY COMPLETED** Claim Form to:
HSR Plaza II
4100 Medical Parkway
Carrollton TX 75007
Phone (972) 512-5600 Fax (972) 512-5820
Toll Free (866) 345-0973
E-Mail gisclaims@hsri.com

For questions, inquiries and/or status of your claim call (866) 345-0973