

**MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP.
CN 98000
PENNSAUKEN, NJ 08110
(800) 257-6250**

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.

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|------------------|
| Policy Number |
| Reference Number |
| Claim Number |

SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM.

| PART I – TO BE COMPLETED BY COACH, MANAGER OR PROPERLY DELEGATED AUTHORITY | | | | |
|--|--------------------------|--------------------------|--------------|--|
| 1. Name of School/Organization | | 2. Name of Team | | |
| 3. Name of Injured Individual | | Last | First | Middle Initial |
| 4. Social Security No. | | | 5. Birthdate | |
| 8. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.) | | | | |
| 9. Describe how accident occurred. (Give all possible details.) MUST BE A BODILY INJURY DUE TO ACCIDENT. | | | | |
| 10. Did Accident Occur: | | Yes | No | 11. a) Date of Accident |
| a) While claimant was supervised | <input type="checkbox"/> | <input type="checkbox"/> | | |
| b) During sponsored activity | <input type="checkbox"/> | <input type="checkbox"/> | | |
| c) During programmed hours | <input type="checkbox"/> | <input type="checkbox"/> | b) Time | 12. Name of Activity/Sport |
| d) On activity premises | <input type="checkbox"/> | <input type="checkbox"/> | | 12A. (Check One) |
| e) While traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group. | <input type="checkbox"/> | <input type="checkbox"/> | c) Place | <input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Player/Member |
| 14. Signature of Coach, Manager or Delegated Authority | | 15. Title | | 16. Date |

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL

| PART II – TO BE COMPLETED BY CLAIMANT – OR BY PARENT IF CLAIMANT IS A MINOR | | | |
|--|---|---|--|
| 1. Name of Father or Guardian or Claimant (if adult) | | 2. Social Security No. | |
| 3. Name of Mother or Guardian or Spouse (if adult) | | 4. Social Security No. | |
| 5. Address of Parents or Guardian/or Claimant | | 5A. Telephone Number | |
| 6A. Father or Guardian's or Claimant's Insurance Company(ies) | 6B. Mother or Guardian's or Spouse's Insurance Company(ies) | Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group | |
| 7A. Name, Address and Phone Number of Father or Guardian's or Claimant's Employer | | 7B. Name, Address and Phone Number of Mother or Guardian's or Spouse's Employer | |
| 8. List other insurance policies under which claimant is insured Company | | Policy No. | <input type="checkbox"/> Individual <input type="checkbox"/> Group |
| 1. _____ | | 1A. _____ | <input type="checkbox"/> Individual <input type="checkbox"/> Group |
| 2. _____ | | 2A. _____ | <input type="checkbox"/> Individual <input type="checkbox"/> Group |

Affidavit: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent or Guardian or Claimant _____ Date _____

Authorization: I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Claimant (Parent or Guardian if Insured is a minor) _____ Date _____

Accident insurance coverage is available to protect insureds against accidental injury or death occurring while the policy is in force. **Maksin Management Corp** is the administrator of this coverage.

Benefits are provided for covered expenses incurred within a certain time period* after the date of the accident.

Full Excess means that benefits are payable for covered expenses that are in excess of other valid and collectible insurance.

You must submit your claim to your insurance company first. When you receive their Explanation of Benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy.

Primary Excess means that benefits are payable for the first \$100 of eligible covered expenses, without regard to other insurance. Additional eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance.

Submit your claim to Maksin Management Corp first. We will pay the first \$100 of eligible covered expenses. You must then submit your claim to your insurance company. When you receive their Explanation of Benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits, otherwise our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.

CLAIM INSTRUCTIONS

In case of accident, notify the school immediately.

1. Treatment must commence within 90 days from the date of the injury.
2. Send this claim form to us within 90 days from the date of the injury. **DO NOT** leave this form with the school, organization, coach, hospital, physician, etc.
3. Do not leave any blank spaces or write "N/A" in a space. If either parent is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you do not have insurance, please state "no insurance". If you are employed, please provide us with a statement from your employer that the claimant has no insurance. (Our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage).
4. If claimant is insured under Medicaid, please indicate this.
5. Please attach itemized bills to the claim form, or mail them as soon as possible. An itemized bill includes treatment rendered, the dates of the treatment, physician's or hospital's name, address and tax I.D. number, and diagnosis code. Balance Due bills are **not** acceptable.
6. If you have other insurance, your insurance company will send you an Explanation of Benefits (EOB) which shows what they paid or denied. We need a copy of the EOB for each itemized bill submitted to us.
7. Or, your provider(s) may forward the itemized bills to us along with the corresponding EOBs.
8. Our address is **Maksin Management Corp, CN 98000, Pennsauken, NJ 08110**. Customer Service can be reached on **800-257-6250**. We will be happy to assist you.
9. Benefits are paid to the providers of service unless we receive paid receipts.

•All policies have a limited benefit period. The insured will be covered for a minimum of one year from the date of the accident. For the exact benefit period of the claim, contact Maksin Management or your school/organization.