

CHARTIS

Accident & Health Claims Department
PO Box 25987
Shawnee Mission, KS 66225



800 551 0824 Telephone
866 893 8574 Facsimile

A&H.Claimssubmissions@chartisinsurance.com

Dear Policyholder,

Attached is a copy of the Special Risk claim form you requested. Please read the following information and instructions very carefully as all of the information is required for us to begin reviewing your claim.

- Each person filing a claim will need to submit a separate claim form.
- All sections of the claim form must be completed in detail paying special attention to the following:
 - o Please ensure that you complete the section on How, When and Where Accident Occurred to include the Date and Time of the accident.
 - o Please ensure that the Policyholder (National Youth Sports Leagues) signs at the bottom of Section A
 - o Please ensure that the claimant (injured party) signs at the bottom of the claim form
- Attach itemized bills provided by the providers/facilities (HCFA 1500 for Providers and UB92/UB04 for facilities) for all medical expenses being claimed which must include the following:
 - o Claimant' name
 - o Condition being treated (Diagnosis/Diagnosis Codes)
 - o Description of services rendered (Standardized Procedure Codes)
 - o Dates and Charges for each service provided
 - o Provider's Federal Tax Id Number
- If your policy is an Excess policy (meaning you have other primary insurance), we will need the Explanation of Benefits (EOBs) from your primary insurance company confirming what they have paid sent in with the claim form and itemized bills

Once your claims package is received, it will take approximately 10-15 business days to review your claim. Failure to submit all requested documents could result in a delay of the claims process. Please keep in mind that all decisions regarding claims will be made by the Claims Department and will be based on the documentation provided when the claim is filed.

If you have questions/comments, please contact our Customer Service Department at 1-800-551-0824.

Regards,

Customer Service Department Chartis Accident & Health

National Union Fire Insurance Company of Pittsburgh, PA
Chartis Accident & Health
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-893-8574 (Facsimile)

PROOF OF LOSS

NAME OF GROUP: National Youth Sports Leagues

POLICY NUMBER: 9125132

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

- 1.) You must have SECTION A fully completed by a designated official of the Policyholder.
- 2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
- 3.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.

primary plan - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum. EXCESS plan - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	NAME OF SUPERVISOR
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<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	U.S. CITIZEN <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF BIRTH	DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED
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NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).
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NAME OF ACTIVITY	DID ACCIDENT OCCUR:
INDICATE THE SPORT (IF APPLICABLE)	A. WHILE CLAIMANT WAS SUPERVISED <input type="checkbox"/> YES <input type="checkbox"/> NO
	B. DURING SPONSORED ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO
	C. DURING PROGRAMMED HOURS <input type="checkbox"/> YES <input type="checkbox"/> NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN SUPERVISED GROUP <input type="checkbox"/> YES <input type="checkbox"/> NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS
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POLICYHOLDER REPRESENTATE NAME(PLEASE PRINT)	SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DAYTIME TELEPHONE NUMBER	DATE
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SECTION B - MUST BE COMPLETED

DO YOU HAVE OTHER HEALTH INSURANCE Yes ____ No ____

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #
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IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT	SOCIAL SECURITY NUMBER / DATE OF BIRTH /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> U. S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
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ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER
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NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE #
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I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

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.

Rhode Island : 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

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

For claimants not residing in California, Rhode Island, New York, or Pennsylvania: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE

DATE

Section C

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS CHAMPVA GROUP HEALTH PLAN <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER
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2. PATIENT'S NAME (First Name, Middle Initial, Last Name)	3. PATIENT'S DATE OF BIRTH MM / DD / YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (First Name, Middle Initial, Last Name)
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5. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____	6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY)	7. INSURED'S ADDRESS (No., Street) CITY _____ STATE _____
ZIP CODE _____ TELEPHONE NO. _____	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	ZIP CODE _____ TELEPHONE NO. _____
9. OTHER INSURED'S NAME	Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER

A. OTHER INSURED'S POLICY OR GROUP NUMBER	10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> D. RESERVED FOR LOCAL USE	B. EMPLOYER'S NAME OR SCHOOL NAME
B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY M <input type="checkbox"/> F <input type="checkbox"/>		C. INSURANCE PLAN NAME OR PROGRAM NAME
C. EMPLOYER'S NAME OR SCHOOL NAME		D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to & complete item 9 A-D
D. INSURANCE PLAN NAME OR PROGRAM NAME		

<p>12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>Signature _____ Date _____</p>	<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described below.</p> <p>Signature _____ Date _____</p>
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14. DATE OF CURRENT: MM / DD / YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY	16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / /
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / /

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____
1 _____ 3 _____	23. PRIOR AUTHORIZATION NUMBER
2 _____ 4 _____	

24. A	B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM MM/DD/YY	DATE(S) OF SERVICE TO MM/DD/YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN _____ EIN _____	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office.)	33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE # PIN# _____ GRP# _____
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PLACE OF SERVICE CODES 1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE	4-(H)-PATIENT'S HOME 5- -DAYCARE FACILITY (PSY) 6- -NIGHT CARE FACILITY(PSY)	7-(NH) NURSING HOME 8-(SNF)-SKILLED NURSING FACILITY 9- -AMBULANCE	O-(OL)-OTHER LOCATIONS A-(IL)-INDEPENDENT LABORATORY B- -OTHER
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