

Athletics Claim Submission Process

1. Submit claims online at www.collegesportsinsurance.com
2. If you need log in credentials please contact Janice Briggs (Janice.Briggs@relationinsurance.com).
3. In the event the site is down and/or you are unable to access it, then please complete the athletics injury claim form and submit it to Tanya.brown@mutualofomaha.com

Claim Form

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries
1-800-524-2324



SEE REVERSE SIDE FOR FRAUD LANGUAGE

To Be Completed By Organization/School

Policy Number: _____
 Organization/School Name: _____
 Address: _____
 Phone No. (_____) _____ - _____
 Name of team/sport (if applicable): _____
 Type of Activity _____
 Interscholastic/intercollegiate P.E. class _____
 Intramural Practice Game Jr. Varsity Varsity _____
(activity involved)
 Dates of event (if student-date school started): _____
 At the time of injury, was the insured involved in an activity sponsored by the Policyholder? Yes No
 Under whose supervision? _____ Was he/she a witness? Yes No
 If employed, was injury/sickness related to claimant's employment? Yes No

Type of Benefits Claimed

Accident-Medical Date of Accident _____
 Location of accident _____
 Description of accident _____
 Type of injury or illness _____
 First treatment date _____
 Dates claimed _____
 Dental
 Sickness-Medical
 Loss of Time

Dated: _____
Signature of Organization/School Official & Title _____

To Be Completed By Claimant — Or By Parent/Legal Guardian If Claimant Is A Minor

Claimant's Name: _____
 Date of Birth: _____ Age: _____ Male Female
 Address of Parents, Guardian or Claimant: _____
 Home Phone No. (_____) _____ - _____

Name and address of Family Physician: _____
 Phone No. (_____) _____ - _____
 Has treatment been completed? Yes No

Father, Guardian or Claimant's (if adult)
 Employer, Name and Address: _____
 Phone No. (_____) _____ - _____
 Mother or Spouse's Employer, Name and Address: _____
 Phone No. (_____) _____ - _____

Name of all companies providing your insurance coverage or prepaid health plans.

Name of Company	Address	Policy or Certificate No.
_____	_____	_____
_____	_____	_____

 Individual
 Group (Eff. Date _____)

Are benefits due for this claim under these other insurance coverages? Yes No (See reverse side for Important Notice)

I hereby certify that all above information is true and complete.
Signature _____ Date _____

- ** **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.
- ** **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.