FCSRMC

FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

Intercollegiate Athletics Claim Submission Process

1. Submit claims online at www.collegesportsinsurance.com

2. If you need log in credentials and/or are experiencing issues logging into the site, then please contact nhammond@americanspecialty.com with bgilliam@fcsrmc.com and stephanie.williams@ahpcare.com copied.

3. In the event the site is down and/or you are unable to access it, then please complete the claim form on the following pages and email it along with any other supporting documentation you have to Kayla.Clark@mutualofomaha.com and Adriene.Deramus@mutualofomaha.com with stephanie.williams@ahpcare.com and bgilliam@fcsrmc.com copied

Claim Form

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

Mutual of Omaha

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 _____
(activity involved)
☐ Intramural ☐ Practice ☐ Game ☐ Jr. Varsity ☐ Varsity
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
☐ Dental
☐ Sickness-Medical
☐ Loss of Time

Date of Accident _____
Hour a.m. p.m.
Location of accident _____
Description of accident _____
Type of injury or illness _____
First treatment date _____
Dates claimed _____

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.