

# Claim Form

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



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## 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 \_\_\_\_\_  
Hour a.m. p.m.  
 Dental Location of accident \_\_\_\_\_  
 Sickness-Medical Description of accident \_\_\_\_\_  
 Type of injury or illness \_\_\_\_\_  
 Loss of Time 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: \_\_\_\_\_  
 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  
**If yes, attach copies of explanation of payments from primary carrier.**

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

**Payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.**

### **Important Claim Notice**

**California Residents:** 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.

**District of Columbia & Pennsylvania Residents:** 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.

**Florida Residents:** 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 Residents:** 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.

**Minnesota Residents:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Jersey Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York Residents:** 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 Residents:** 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.

**Texas Residents:** 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.

**For All States Other Than Those Above:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. This notice does not apply in Virginia.