



# USA VOLLEYBALL MEDICAL CLAIM FORM 2018-2019 Season

**SEND THIS FORM TO:**  
 American Specialty Insurance & Risk Services, Inc.  
 7609 W. Jefferson Blvd.  
 Suite 150  
 Ft. Wayne, IN 46804  
 Customer Service Number: 800-245-2744  
 Email: claimsPA@americanspecialty.com

This form should be completed whenever a medical claim results from an injury incurred at USA Volleyball sanctioned events.

**PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.**

TO BE COMPLETED BY INJURED PARTY						
NAME (Last Name)	(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS (Street) (City) (State) (Zip Code)						
TELEPHONE NUMBER ( )			OCCUPATION			
USA VOLLEYBALL PARTICIPANT #:			DATE & TIME OF ACCIDENT: ____/____/____ ____ AM ____ PM			
INJURED PARTY WAS: <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> COACH <input type="checkbox"/> OFFICIAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER: _____ IF PARTICIPANT, MEMBERSHIP TYPE: <input type="checkbox"/> JUNIOR MEMBER <input type="checkbox"/> ADULT MEMBER <input type="checkbox"/> NATIONAL OR HIGH PERFORMANCE TEAM MEMBER						
REGIONAL ASSOCIATION NAME:			COACHES NAME:		PHONE #: ( )	
NATURE OF INJURY						
<b>FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:</b>						
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT:						
B. DESCRIBE WHERE ACCIDENT HAPPENED:						
C. DESCRIBE HOW ACCIDENT HAPPENED:						
D. DID THE ACCIDENT OCCUR DURING: <input type="checkbox"/> COMPETITION <input type="checkbox"/> PRACTICE <input type="checkbox"/> TRAVELING TO/FROM <input type="checkbox"/> OTHER: _____						
E. WITNESS NAME: _____			PHONE #: _____			
IF INJURED PARTY IS A MINOR:						
PARENT/GUARDIAN NAME: _____			HOME PHONE #: _____			
EMPLOYER NAME: _____			WORK PHONE #: _____			
IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO						
IF YES, NAME OF INSURANCE COMPANY				POLICY NUMBER		
ADDRESS (Street) (City) (State) (Zip Code)						
<b>AUTHORIZATION TO RELEASE INFORMATION</b>						
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.						
NAME OF PATIENT			SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)		DATE	
I certify that the foregoing information is true and correct.			SIGNATURE		DATE	

The completion of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.