ACCIDENT INSURANCE CLAIM FORM

MAIL TO: COLE INSURANCE AGENCY – PO BOX 600183, DALLAS, TX 75360-0183
(Phone) 1-214-823-2653 / (Fax) 1-214-823-3805

The following must be completed, dated and signed by an official of the Organization

Name of Organization (Policyholder) ____ Policy Number ______________

Name of Organization of Team (if different from policyholder) ____

Address of Organization ____
Number and Street City State Zip Code Phone Number

Name of Injured Person ____

At the time of injury, was the person involved in an activity under the jurisdiction of the Organization (Policyholder)?

☐ No ☐ Yes If yes, under whose supervision? ____

____

Was He / She a witness? ☐ No ☐ Yes

Did the injury occur during: ☐ Practice ☐ Travel ☐ Game ☐ Other___________________________________

Date & time of injury _____________________________ Date of 1st treatment_______________________________________

Type of Sport or Activity____

Describe how and where accident occurred: ____

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Nature of injury____

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Print Name of Organization Official _______________________________________ Title______________________________

Organization Official's Signature____ Phone No._________________

CrAc 09/07

THE FOLLOWING MUST BE COMPLETED BY THE INJURED PERSON OR IF THE INJURED PERSON IS UNDER THE AGE OF 18 OR OTHERWISE DEPENDENT – BY HIS/HER/ PARENT OR GUARDIAN

Claimant's Name________________________________ SS Number ____________
Last Name First Name M.I.

Current Home Address ________________________________
Number and Street City State Zip Code Phone Number

Date of Birth________________ ❑ Male ❑ Female

Employer Name ________________________________

Employer Address ________________________________
Number and Street City State Zip Code Phone Number

PARENT (OR GUARDIAN) INFORMATION (must be completed if claimant is under 18 years of age)

Name of Father or Male Guardian________________________________ SS Number ____________

Current Home Address ________________________________
Number and Street City State Zip Code Phone Number

Employer Name ________________________________

Employer Address ________________________________
Number and Street City State Zip Code Phone Number

Name of Mother or Female Guardian________________________________ SS Number ____________

Current Home Address ________________________________
Number and Street City State Zip Code Phone Number

Employer Name ________________________________

Employer Address ________________________________
Number and Street City State Zip Code Phone Number

Is the claimant covered under any other insurance policy? ❑ No ❑ Yes

Name of Policyholder ________________________________ Individual or Group

Name of Carrier ________________________________ Policy No. ____________

Carrier's Address ________________________________
Number and Street City State Zip Code Phone Number

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Name of Carrier ________________________________ Policy No. ____________

Carrier's Address ________________________________
Number and Street City State Zip Code Phone Number

If other insurance exists, all claims must be submitted to the other insurance policies first. A copy of the itemized bills along with the other carrier's corresponding Explanation of Benefits should be submitted for consideration.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Fairmont Specialty, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original.

X________________________________ Date: ____________

Signature of Parent/Guardian or Claimant (if 18 years or older)

IMPORTANT NOTICE

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Arizona Claimants: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to California Claimants: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Hawaii Claimants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Idaho Claimants: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete, or misleading information is guilty of a felony.

Notice to Kentucky Claimants: 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.

Notice to Oklahoma Claimants: 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.

Notice to Pennsylvania Claimants: 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.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.