



1. Please fully complete this form  
 2. Please print or type  
 3. Mail to:  
 USA Wrestling  
 Notice of Injury  
 6155 Lehman Drive  
 Colorado Springs, CO 80918

HSR Plaza II  
 4100 Medical Parkway  
 Carrollton, Texas 75007  
 Fax: (972) 512-5820  
**Toll Free (866) 523-3199**

Wrestling Card Number: \_\_\_\_\_

Class 1  Class 2

**PART I – POLICYHOLDER'S REPORT**

1. Claimant's Name (Injured Person)		2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. E-Mail
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)					
7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)					
8. Date and Time of Accident		9. Place where Accident Occurred		10. The injured person was a: <input type="checkbox"/> Wrestler <input type="checkbox"/> Coach <input type="checkbox"/> Official	
Dental Claims	11. Indicate which Teeth were Involved in the Accident		12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)				Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident					
15. Did Accident Occur (Check Yes or No for Each of the Following):					
A. While at practice?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
B. While at an event?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
C. On activity premises?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
D. While traveling directly and uninterruptedly to or from school and competition?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Name of Event			17. Name and Title of Supervisor		
18. Name of Policyholder <b>USA Wrestling</b>		19. Address of Policyholder (Address, City, State, Zip) <b>6155 Lehman Drive, Colorado Springs CO 80918</b>			
20. Signature of Policyholder Representative			21. Title of Policyholder Representative		22. Date

**PART II – OTHER INSURANCE STATEMENT**

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree?  YES  NO

If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Claimant's primary employer name, address, and phone number \_\_\_\_\_

Mother's primary employer name, address, and phone number \_\_\_\_\_

Father's primary employer name, address, and phone number \_\_\_\_\_

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
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**PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Accident** insurance coverage is available to protect insureds against accidental injury or death occurring while the policy is in force. **Health Special Risk, Inc.** is the administrator of this coverage.

Benefits are provided for covered expenses incurred within a certain time period after the date of the accident.

**Full Excess** means that benefits are payable for covered expenses that are in excess of other valid and collectible insurance.

You must submit your claim to your personal insurance company first. When you receive their Explanation of Benefits (EOB), send it to us, along with corresponding itemized bills. We will pay benefits for eligible expenses per the terms of the policy.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.

#### CLAIM INSTRUCTIONS

**In case of accident, notify the school immediately.**

1. Treatment must commence within 30 days from the date of the injury.
2. Send this claim form to us within 90 days from the date of the injury. DO NOT leave this form with the school, organization, coach, hospital, physician, etc.
3. Do not leave any blank spaces or write "N/A" in a space. If either parent is uninjured, deceased, unemployed, self-employed or disabled, please state so. If you do not have insurance, please state "no insurance". If you are employed, please provide us with a statement from your employer that the claimant has no insurance. Our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.
4. If claimant is insured under Medicaid, please indicate this.
5. Please attach itemized bills to the claim form or mail them as soon as possible. An itemized bill includes treatment rendered, the dates of the treatment, physician's or hospital's name, address and tax I.D. number, diagnosis, and procedure codes. Balance Due bills are **not** acceptable.
6. If you have other insurance, your insurance company will send you an Explanation of Benefits (EOB), which shows what they paid or denied. We need a copy of the EOB for each itemized bill submitted to us.
7. Or, your provider(s) may forward the itemized bills to us along with the corresponding EOBs.
8. Our address is **Health Special Risk, Inc., HSR Plaza II, 4100 Medical Parkway, Carrollton, Texas 75007**. Customer Service may be reached toll-free at **866-523-3199** 7:00 a.m. to 7:00 p.m. (Central time). We will be happy to assist you.
9. Benefits are paid to the providers of service unless we receive paid receipts.

All policies have a limited benefit period. The insured will be covered for a minimum of one year from the date of the accident. For the exact benefit period of the claim, contact Health Special Risk, Inc. or your school/organization.

#### USA WRESTLING SPORTS ACCIDENT INSURANCE PROGRAM CLAIM FILING INSTRUCTIONS

The instructions below and the attached form(s) are provided for your help in expediting your secondary sports accident insurance claims with the Sports Accident Insurance carrier. Please follow all instructions and fill-out all forms completely.

1. If your minor child or you are injured while participating in a covered USA Wrestling event, please complete the attached Health Special Risk claim form and forward it to USA Wrestling. **(Must be submitted within 1 year of date of injury.)**
2. Please be reminded that medical service bill(s) related to your injury, occurring at a USAW sanctioned activity, must first be filed with your primary medical insurance carrier. **Please also note medical attention has to be received within 90 days from date of injury.**
3. **IMPORTANT:** In order to be eligible for any secondary sports accident insurance benefits, you must follow all requirements and conditions under your primary carrier's plan or policy.
4. The attached form(s), with supporting documents (see below) may only be filed after the claim(s) has/have been processed by your primary medical insurance carrier. (See #3 above).
5. Note that the Secondary Sports Accident Insurance coverage carries with it a **\$500.00 per membership year deductible and an 80/20 co-insurance limit up to \$2,000.00 out-of-pocket, excluding deductible.**
6. If your total medical bill(s), after being processed by your primary medical insurance carrier, (see #3 above), exceed \$500.00 then proceed to #7 below. If you do not have a primary insurance carrier, then proceed to #9 below.
7. Please make copies of medical bill(s) and primary insurance carrier's "Explanation of Benefits" (EOB).
8. Once you have received an EOB report from your primary medical insurance carrier, submit items listed below to **Health Special Risk, Inc., 4100 Medical Parkway, Carrollton, TX, 75007**:  
What to submit:
  - (a) Copy of the EOB.
  - (b) Copy(ies) of itemized medical bill(s), which include diagnosis and procedure codes.
  - (c) Copy of completed claim form.
9. If you do not have a primary medical insurance carrier, please complete the attached form and submit, with itemized medical bill(s) to:  
**Health Special Risk, Inc., 4100 Medical Parkway, Carrollton, Texas 75007**
10. You will also have to provide a **notarized** letter stating there is no other insurance in force for the injured party.
11. Keep a copy of each form and item submitted for processing.
12. If you have specific questions concerning your claim, please contact Health Special Risk, Inc. at 866-523-3199 or 972-512-5600; 7:00 a.m. to 7:00 p.m. (Central Time). Please have the social security number of the injured party and the date of the injury available for the service representative.

## FRAUD STATEMENTS

### FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Alaska and Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

**Arizona:** 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.

**Arkansas, Louisiana, Maryland, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form: 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.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Connecticut:** This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

**Delaware, Idaho, Indiana:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida: WARNING :**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.

**Hawaii:** 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.

**Georgia:** Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:

a) In any written statement;

b) In the filing of a claim; or

c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;

3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or

4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

**Michigan, North Dakota, South Dakota:** Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

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

**Nevada:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

**New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

**New Mexico and 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.

**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.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**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.

**Oregon:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Tennessee, Virginia, Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**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.

**Virginia:** Any person who, with the 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 may have violated state law.