Claim Form

Complete and return this form to:

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

Section I Organization/School and Claimant Information (required)

TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL

Policy Effective Date 08/01/2023

Policy Expiration Date 08/01/2024

Policy Number SR2014AZ-P-052036

Claim being filed is a:

- ☐ Noncatastrophic claim
- ☐ Catastrophic claim

Policyholder Name Maricopa Community College District

Policyholder Address 2411 West 14th Street (Street) Tempe (City) Arizona (State) 85281 (ZIP Code)

Policyholder Phone Number (480) 731-8879

Injured Party (Claimant) Information

Name _____ (First) (Last)

Address _____ (Street) (City) (State) (ZIP Code)

Phone Number _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Claimant is a: ☐ Player ☐ Coach ☐ Official ☐ Other _____

Verify that accident occurred during an activity sponsored or sanctioned by the policyholder, and whether claimant was a member at the time of the accident.

☐ Yes – Sponsored/Sanctioned activity

☐ Yes – Claimant was active member on date of accident

Under whose supervision? _____

Was he/she a witness? ☐ Yes ☐ No

Name of team/sport _____

Date of accident _____ Time of accident _____ ☐ a.m. ☐ p.m.

Location of accident _____

Type of activity _____

Accident occurred during: ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Interscholastic/Intercollegiate Sport ☐ Intramural Sport ☐ Other _____

I certify that the above information is true and correct.

Authorized Signature _____

Title _____ Date _____

Section II Additional Claim Details (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

Claimant Name _____

Describe accident _____

Body part injured _____

First treatment date _____

Dates claimed _____

Type of benefits claimed: ☐ Accident-Medical ☐ Dental ☐ Sickness-Medical ☐ Loss of Time

Name of family physician _____

Address _____

Phone Number _____

Has treatment been completed? ☐ Yes ☐ No

Section III Statement of Other Insurance (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

Father/Guardian Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Employer _____

Employer Phone Number _____ ☐ Self-Employed ☐ Unemployed

Mother/Guardian Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Employer _____

Employer Phone Number _____ ☐ Self-Employed ☐ Unemployed

Is Claimant covered under any other medical and/or dental insurance policy? ☐ Yes ☐ No

Is Claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐ Yes ☐ No

Important Notice: This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with an itemized bill and this completed form.

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.

Details of Other Insurance Coverage (required)
COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

Insured Name _____ I.D. Number _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Insured Group Number/Name _____

Company Name _____

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

**Please include copy of insurance card (both sides)

Note: If your son or daughter has medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party:

Responsible Party Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Section IV Statement of Certification (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York 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 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)

Signature of Parent/
Guardian/Claimant (required) _____ Date _____

Section V Authorization to Release Information (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha Insurance Company or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Parent/
Guardian/Claimant (required) _____ Date _____

Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

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

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information 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 and Rhode Island:** 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.

** **Delaware:** 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 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:** 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.

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

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

** **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.

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

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

** **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 of 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:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **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 the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose 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.

** **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 is related to a claim by the claimant.