

Accident Claim Form

MAIL TO: NAHGA Claim Services
PO Box 189
Bridgton, ME 04009

FAX: 207-647-4569

EMAIL TO: claims@nahga.com

QUESTIONS: 800-952-4320

Fairmont

Specialty[®]

part of **Crum&Forster** group

MAGNACARE[™]



In NY, network access provided by MagnaCare.
Outside the MagnaCare network, access will be provided by First Health.

CAUTION: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. **Residents of the following states, please see reverse side: AZ, CA, CO, HI, ID, KY, OK, PA, TX.**

INSTRUCTIONS

The policy is Full Excess unless otherwise noted in the policy. Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You **must** submit your claim to your other insurance company first. When you receive their Benefits Statement (EOB) send it to us along with the itemized bills.

- **Part I** - Must be completed by Policyholder.
- **Part II** - Must be completed by claimant or by the parent or guardian, if the claimant is a minor.
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

PART I - POLICYHOLDER REPORT

Name of Policyholder			Policy Number	
Policyholder Street Address		City	State	Zip Code
Policyholder Contact		Telephone No.	Fax No.	E-Mail
Name of Claimant (Last Name)		Name of Claimant (First Name)		Social Security No.
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade (if applicable)	Check One (if applicable) <input type="checkbox"/> Day School <input type="checkbox"/> Boarding School	

Nature of Injury (Describe, fully indicate what part of body was injured - e.g. broken arm, sprained ankle)

Describe how the Accident occurred, provide all details. Attach a separate sheet, if necessary. **MUST BE A BODILY INJURY DUE TO ACCIDENT.**

Did Accident occur:

While claimant was policyholder supervised?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident: _____	Time of Accident: _____
During a policyholder sponsored activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Accident: _____	
During scheduled policyholder hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	First Treatment Date: _____	
While traveling to or from a policyholder sponsored and supervised activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Off Policyholder premises, at home, during the weekend, holiday or summer vacation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Name and title of person supervising activity? _____	Was he or she a witness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

List other Policyholder insurance. Attach separate sheet, if necessary.

Policy Number(s)

Signature of Authorized Policyholder Representative

Title

Date

PART II - TO BE COMPLETED BY CLAIMANT OR PARENT / GUARDIAN, IF CLAIMANT IS A MINOR

Name of Father or Guardian		Social Security No.		E-Mail Address	
Name of Mother or Guardian		Social Security No.		E-Mail Address	
Street Address of Parents or Guardian		City	State	Zip Code	Telephone No.
Father or Guardian's Insurance Company			Mother or Guardian's Insurance Company		
Name & Address of Father and Mother's or Guardian's Employer		Address	City	State	Zip Code

(Over)

PART II - TO BE COMPLETED BY CLAIMANT OR PARENT / GUARDIAN, IF CLAIMANT IS A MINOR (Continued)

List all other insurance policies under which claimant is insured

Policy Number

Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (*front and back*).

Preferred Provider Organization (PPO) or similar prepaid health plan? Yes No

If Yes, name of PPO or Organization _____

Health Maintenance Organization (HMO) or similar prepaid health plan? Yes No

If Yes, name of HMO or Organization _____

If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:

Name of Policyholder

Name of Insurance Company

Policy Number

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any Fairmont company, the Plan Administrator or their employees and authorized agents for the purpose of validation and determining benefits payable. This data may be extracted for the use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of this claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

Signature (*Parent or Guardian, if the claimant is a minor*)

Date

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.