

Please print or type. Incomplete forms will be returned.
 SEND COMPLETED FORM & BILLS TO:



Clear Form

Print Form

Daniel Valle, 1st., VP, JSPWFL
 594 Beachway Ave
 Keansburg, NJ 07734

Underwritten by: American International Group, Inc.

IMPORTANT NOTICE:
 If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, please send it to us with the corresponding itemized bills.

PART 1: POLICYHOLDER & INSURED				
(1) School/Organization/Group Name Pop Warner Little Scholars Inc.		(2) Policy Number SRG9108336		
(3) Claimant - Last Name, First Name		(4) Claimant Social Security Number	(5) Claimant Type (please choose)	
(6) Mailing Address where Insurance Info/Requests should be mailed		(7) City, State, Zip		
(8) Birthdate	(9) Male <input type="checkbox"/> Female <input type="checkbox"/>	(10) Home Phone	(11) Alternate Phone	
(12) League (Example: Central Ohio)		(13) Association (Example: Columbus Titans)	(14) Team Description (please choose one)	
(15) If claimant is an adult, name and address of Employer:				

PART 2: INJURY DETAILS				
(1) Date of Injury	(2) Time & Address where occurred?		(3) Sport (please choose one)	
(4) Description of injury and how it occurred?			(5) Part of body injured	
(6) Date of first medical treatment	(7) Action Taken: <input type="checkbox"/> Released to Parent <input type="checkbox"/> Ambulance Transport <input type="checkbox"/> Refused Care <input type="checkbox"/> Referred to Hospital/Clinic <input type="checkbox"/> Own Accord (Adult)			
(8) Was the claimant supervised when injured? Yes <input type="checkbox"/> No <input type="checkbox"/>		(9) Was injury during sponsored activity? Yes <input type="checkbox"/> No <input type="checkbox"/>		
(10) Was injury during travel to or from scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/>		(11) If claimant is adult, is claimant unable to work as result of injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date last worked:		
(12) Print Name of Supervisor/Official/Policyholder Representative		(13) Signature of Supervisor/Official/Policyholder Representative		Date

PART 3: PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)				
(1) Father/Guardian Name	Telephone	(7) Mother/Guardian Name	Telephone	
(2) Home Address (Street, City, State, Zip)		(8) Home Address (Street, City, State, Zip)		
(3) Employer		(9) Employer		
(4) Father's Employer Address (Street, City, State, Zip)		(10) Mother's Employer Address (Street, City, State, Zip)		
(5) Business Phone		(11) Business Phone		
(6) Employer Medical Insurance Policy		(12) Employer Medical Insurance Policy		
(6a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>		(12a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>		

PART 4: INSURANCE VERIFICATION	
Is Claimant covered by any other insurance policy (other than this policy), either as an individual, dependent, group, automobile medical or liability? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please list name of insurance carrier: _____	
Please note that if other insurance exists, all claims must be submitted to that other insurance policy first	

PART 5: AUTHORIZATION	
I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Student to disclose when requested to do so, any information to NAHGA CLAIM SERVICES with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photo static copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.	
X	
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age)	Date
AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.	
X	
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age)	Date
<i>Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.</i>	