CLAIM FILING NOTICE-BSR

This claim form MUST be received by the Great American Insurance Company within 90* days of the date of injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52* weeks after the date of the accident.

*As otherwise noted in the Policy

CLAIM PROCEDURE

1. Have a Representative of the Policyholder complete, date and sign PART A.
2. The Injured Person (Insured) – or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian – MUST complete, date and sign PART B.
3. After PARTS A and B have been completed in full, mail the form to the address shown above within 90 days of the date of injury.
4. Send all medical bills to your other health and accident insurance company(s) first, if applicable. This can include employee plans, union plans, service contracts, HMO Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment from your other health and accident insurance company(s), notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown above. You may also fax or email. Please see contact information shown above.

Great American Insurance Group, 301 E. Fourth St., Cincinnati, OH 45202. This is an accident only policy with limited benefits and does not pay benefits for diseases, sickness or loss from sickness. Coverage is summarized. Coverage features and product availability may vary by state. This is not a contract for the coverage described herein. Please contact us or your agent/broker for additional information, and refer to the actual policy for a full description of applicable terms, conditions, limits and exclusions. Policies are underwritten by Great American Insurance Company, an authorized insurer in all 50 states and the DC. © 2020 Great American Insurance Company. All rights reserved. 5335-ACH-2 (9/20)

Powered by Great American Insurance Company
301 E 4th Street
Cincinnati, OH 45202
underwriting@getpomi.com

Notice of Accident – BSR

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Mail Claim Forms To: Co-ordinated Benefit Plans, PO Box 21282, Tampa, FL 33622

If You Need Assistance: **Toll Free** 1-877-477-4209 **Email** GAICClaims@cbpinsure.com

Part A Claim Form

1. Full Name *(Injured Person)* ____________________
2. Date of Birth ____________________ 3. Telephone Number ____________________
4. Email Address ____________________ 5. Secondary Email Address ____________________
6. Street Address ____________________
7. City ____________________ State ____________ Zip ____________
8. Policyholder Name United States Premier Hockey League
9. Policy Number BSR E880709- 00
10. Date of Injury ____________________ 11. Time of Injury __________ ☐ AM ☐ PM
12. If Hospitalized, Hospital Name ____________________ Hospital Tel. No. ____________________
13. Street Address ____________________
14. City ____________________ State ____________ Zip ____________
15. Hospital Confinement Dates From ____________ To ____________
16. Explain **how** the accident and injury occurred.
    NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.
17. Describe the nature of injury.
18. At what location did the injury occur?

Authorized Representative of The Policyholder

Date ____________________ **Print Name** Debra T. Madden

Signature ____________________ **Telephone No.** 603-886-8885

Part B

This PART MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

Print Here: Name of Person Completing Form ______________________________

Check one: ☐ Injured Person ☐ Parent ☐ Guardian

Give the following information about the Injured Person:

1. Date of Birth ____________________ 2. ☐ Male ☐ Female
3. Social Security No. ____________________ 4. Area Code/Telephone No. ____________________
5. **Employer *(if applicable)***
   Name ______________________________
   Street Address ______________________________
   City ____________________ State ____________ Zip ____________
   Area Code/Employer Telephone No. ______________________________
6. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ☐ No ☐
   If yes, give the following information:
   Name of Other Insurance Company(s) ______________________________
   Street Address ______________________________
   City ____________________ State ____________ Zip ____________
   Area Code/Employer Telephone No. ______________________________
   Policyholder Name ______________________________
   Policy number ______________________________
   Street Address ______________________________
   City ____________________ State ____________ Zip ____________
   Social Security No. ____________________
   Relationship to Injured person ____________________ Area Code/Telephone No. ____________________
7. If the Injured Person is married, give the following information:
   Name of Spouse ______________________________
   Social Security No. ____________________ Area Code/Telephone No. ____________________
8. Is the injured person eligible for Medicare/Medicaid? Yes ☐ No ☐

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also authorize Great American Insurance Company or its agents or representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Great American Insurance Company from liability as to amounts so paid.

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 *(in FL, a felony in the third degree)*, and in the state of New York, 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.

Signature *(in writing)* of Responsible Party ______________________________ **Print Name** ____________________

Check one: ☐ **Injured Person** ☐ **Parent** ☐ **Guardian** **Date** ____________________

SEE FOLLOWING PAGE FOR FRAUD WARNING NOTICES

Fraud Warning Notices

AK: Any 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.

AL: 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.

AR, DC, LA, MD, NM, RI, TX, WV: 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.

AZ: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: 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.

CO: 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DE, ID, IN: 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.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY: Any person who knowingly and with intent to defraud any insurance company or other 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.

ME, TN, VA, WA: 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 denial of insurance benefits.

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

NH: 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 section 638:20.

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

NY: 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.

OH: 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.

OK: Any person who knowingly, and with any 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.

Fraud Warning Notices *Continued*

PA: 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.

ALL OTHER STATES: 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/or civil penalties.

Submit