

# Accident Claim Form

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

**FAX:** 207-647-4569

**EMAIL TO:** [claims@nahga.com](mailto:claims@nahga.com)

**QUESTIONS:** 800-952-4320



**CRUM & FORSTER**  
EST. 1822 A FAIRFAX COMPANY

**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, AK CA, CO, FL, HI, ID, KY, MD, NH, NJ OK, PA, TN, TX, VA.**

## 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) (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. <b>MUST BE A BODILY INJURY DUE TO ACCIDENT.</b>					
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 of all 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.

**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.

**PAYMENT AUTHORIZATION:** I authorize all current and future medical benefits, for services rendered and billed as a result as 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

**CLAIM FORM FRAUD STATEMENT - 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.

**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.

**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.

**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.

**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 of claim containing any false, incomplete, or misleading information is guilty of a felony.

**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.

**NEW HAMPSHIRE:** Any person who, with a purpose to injure, defrauds, 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.

**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.

**OKLAHOMA:** 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.

**TENNESSEE and VIRGINIA:** 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.