



MAIL TO: Co-ordinated Benefit Plans, PO Box 21282, Tampa, FL 33622 or
EMAIL: Team2@CBPINSURE.COM

Policyholder or Certificateholder Name _____ Policy or Certificate No. _____

Claimant's Name _____ Date of birth: _____
Last Name First Name M.I.

Current Home Address _____
No. & Street City State Zip Code Phone No.

Date & time of injury _____ Date of 1st treatment _____

Was the claimant involved in a Policy or Certificateholder sponsored and supervised activity at the time of injury? No Yes

If yes, under whose supervision? _____ Was He/She a witness? No Yes

Type of activity _____ Describe how and where accident occurred: _____

The following must be completed by school official if injury occurred during Policy or Certificateholder activity

Printed Name of Policy or Certificateholder Official _____ Title: _____

Official's Signature _____ Phone No. _____

PARENT (OR GUARDIAN) INFORMATION (must be completed if claimant is a minor)

Name of Mother _____

Name of Father: _____

Address _____
No. & Street City State Zip

Address _____
No. & Street City State Zip

Home Phone No. _____

Home Phone No.: _____

Employer Name _____

Employer Name: _____

Address: _____
No. & Street City State Zip

Address: _____
No. & Street City State Zip

Employer Phone No. _____

Employer Phone No. _____

Is claimant covered under any other insurance policy(s)? No Yes If yes, please provide the following:

Name of Carrier _____ Policy No. _____ Name of Policyholder: _____

Name of Carrier _____ Policy No. _____ Name of Policyholder: _____

NEW YORK FRAUD WARNING: 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.

AUTHORIZATION: I hereby authorize Crum & Forster, United States Fire Insurance Company or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data necessary to determine eligibility of benefits. I also authorize Crum & Forster, United States Fire Insurance Company or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance support organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photo static copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

SIGNATURE OF CLAIMANT (OR PARENT IF 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: 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.

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 WARNING :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.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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 information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

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, 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 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 and 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.

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: 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: 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.

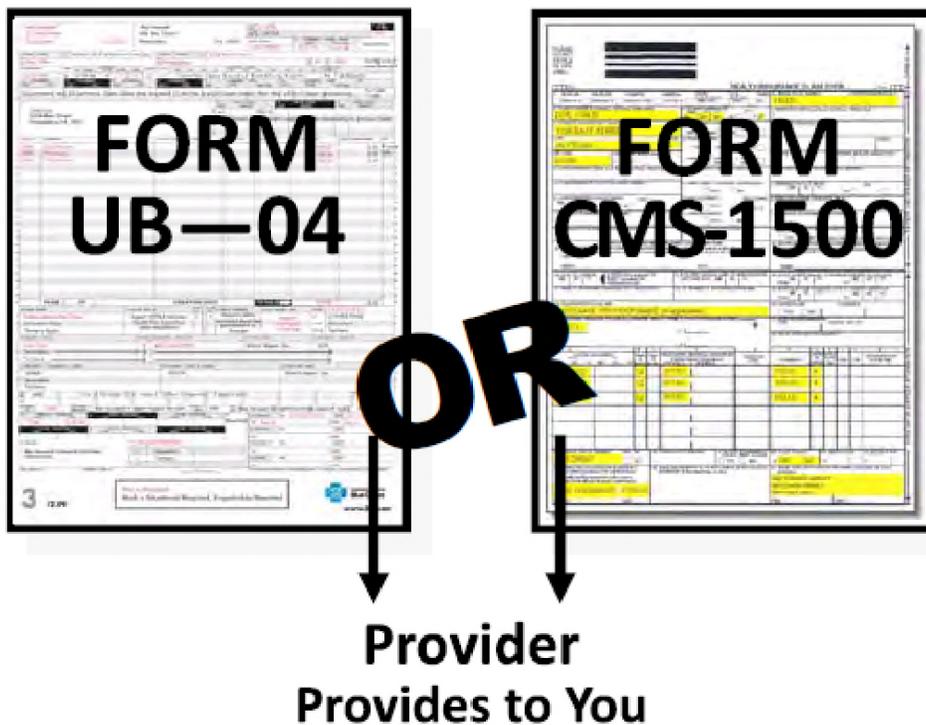
VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

CLAIM FILING NOTICE

This claim form **MUST** be received by the 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.

CLAIM PROCEDURE

1. Have an Official of the Organization **complete, date** and **sign**.
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**.
3. After all has 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, H.M.O. 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.



IF YOU NEED ASSISTANCE: TOLL FREE 1-877-402-1031 / EMAIL: Team2@CBPINSURE.COM