



SPORTS ACCIDENT CLAIM FORM

Policy # SRG-9101737

NOTE: AAU's Accident Medical Coverage is excess. Please submit all charges to your primary medical carrier for review first. Upon reply, forward itemized bills along with Explanation of Benefits from primary Insurer to our attention at the address listed below.

<p>INCIDENT DATE: _____ INCIDENT TIME: _____ AM / PM</p> <p>INJURED PERSON: <input type="checkbox"/> ATHLETE <input type="checkbox"/> NON ATHLETE <input type="checkbox"/> SPECTATOR</p> <p>Was injured person an AAU Member? <input type="checkbox"/> YES <input type="checkbox"/> NO Youth Member? <input type="checkbox"/> Adult Member? <input type="checkbox"/></p> <p>Was the membership Regular? <input type="checkbox"/> Added Benefit? <input type="checkbox"/></p> <p>If injured person is an AAU member, identify: AAU CLUB NAME: _____</p> <p>AAU CLUB # _____ SPORT: _____</p> <p>AAU ASSOCIATION: _____</p> <p>HOSTING CLUB NAME: _____</p>	<p>DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, please provide name of company and policy number. # _____</p> <p>DID THIS TAKE PLACE DURING: <input type="checkbox"/> practice <input type="checkbox"/> competition <input type="checkbox"/> Travel (to or from event) <input type="checkbox"/> Other, _____</p> <p>If during competition, list name of event: _____</p> <p>City & State event took place: _____</p> <p>Did loss take place during AAU sanctioned event? <input type="checkbox"/> YES <input type="checkbox"/> NO AAU Event Sanction # _____</p> <p>NOTE: If the incident occurred during a non-sanctioned event, attach roster listing the names of all athletes and coaches on the injured person's team.</p>
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INJURED PERSON INFORMATION

<p>LAST NAME _____ FIRST NAME _____ MIDDLE _____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p> <p>AGE _____ DATE OF BIRTH _____</p> <p>POSSIBLE PRE-EXISTING CONDITION: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>TELEPHONE NUMBER: () - -</p> <p>SOCIAL SECURITY NUMBER: - -</p> <p><input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED</p> <p>EMPLOYER NAME: _____</p> <p>GUARDIAN / PARENT (IF INJURED PERSON IS A MINOR)</p> <p>LAST NAME _____ FIRST NAME _____ MIDDLE _____</p> <p>ADDRESS _____</p> <p>CITY _____ STATE _____ ZIP _____</p> <p>TELEPHONE NUMBER: () - -</p>																																																																																												
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Send report to: Nahga Claim Service, P.O. Box 189 88 Main St., Bridgton, Maine 04009, Phone 800-952-4320

Fax 207-647-4569 E-mail aau@nahga.com

(11/13/07)



Describe how the incident occurred:

WITNESS INFORMATION (Please Print)

Table with 3 columns: NAME, ADDRESS, TELEPHONE NUMBER. Rows 1.) and 2.)

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."

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties."

For claimants not residing in California, New York, or Pennsylvania: 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.

Assignment of Benefits

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to AIG/NAHGA Claims or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

Signature and name fields for Club Contact/Witness and Member/Guardian/Parent (If Injured is a Minor), including DATE and Phone Number fields.

WHENEVER AN ACCIDENT OCCURS:

An incident report must be completed immediately and mailed to the address shown below. This holds true whether the person involved is a participant or a spectator, or whether or not you feel the incident will result in a claim.

Although you may not have sufficient information to answer all the questions, it is important the form be completed as fully as possible. Do not delay sending in the report form; an incomplete form is better than none at all. Always include your name and daytime telephone number where indicated on the form.

The form contains sections to capture information regarding injury to persons, damage to property, and accidents involving autos.

If you have any questions regarding completion of the form, please call Nahga Claim Service 1-800-952-4320.

REMEMBER! INCIDENT REPORT FORMS MUST BE COMPLETED BY A COACH OR AAU ADMINISTRATOR.

Send To: Nahga Claim Service, P.O. Box 189 88 Main St., Bridgton, Maine 04009, Phone 800-952-4320

Fax 207-647-4569 E-mail aau@nahga.com

(01/17/07)