NATIONAL UNION FIRE INSURANCE COMPANY
MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP.
P.O. BOX 2648
CAMDEN, NJ 08101-2648
(800) 257-6250

NOTIFICATION OF INJURY

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.

Policy Number

FOR OFFICE USE

Reference Number
Coverage Code

FORM MUST BE COMPLETED IN FULL

PART I – ACCIDENT REPORT

1A. Name of Organization

1B. Name of Team

2A. Name of Claimant (Last) (First) (Middle Initial)

2B. Social Security No.

2C. Birthdate

2D. Sex

3. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)

4. Describe how accident occurred. (Please provide all details.) **MUST BE A BODILY INJURY DUE TO AN ACCIDENT.**

5A. Did Accident Occur:	Yes	No
a) while the claimant was supervised?	❑	❑
b) during sponsored activity?	❑	❑
c) during programmed hours?	❑	❑
d) on activity premises?	❑	❑
e) while traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group?	❑	❑

5B. a) Date of Accident

b) Time

c) Place

5C. Name of Activity

5D. (Check One)
❑ Member/Player ❑ Coach ❑ Manager

5E. Name and Title of Supervisor

6A. ____________________
Signature of Coach, Manager or Delegated Authority

6B. ____________________
Title

6C. ____________________
Date

PART II – TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)

1A. Name of Father/Guardian or Claimant (if adult)	1B. Social Security No.	1C. Address/City/State/Zip	1D. Phone Number
2A. Name of Mother/Guardian or Spouse (if adult)	2B. Social Security No.	2C. Address/City/State/Zip	2D. Phone Number

3A. Name of Father/Guardian's or Claimant's (if adult) Employer	3B. Address/City/State/Zip of Employer	3C. Phone Number
4A. Name of Mother/Guardian's or Spouse's (if adult) Employer	4B. Address/City/State/Zip of Employer	4C. Phone Number

5A. Parent/Guardian's or Claimant's (if adult) Insurance Company(ies)

5B. Policy Number(s)

5C.
❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
❑ Medicaid ❑ Individual ❑ Group ❑ Govt.

6A. All other Insurance Company(ies) under which Claimant is insured

6B. Policy Number(s)

6C.
❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
❑ Medicaid ❑ Individual ❑ Group ❑ Govt.

Affidavit: I verify that the above information regarding 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.

Signature of Parent/Guardian or Claimant (if adult) — Date

Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian if claimant is under 18) — Date

SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM

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