CRAWFORD CENTRAL SCHOOL DISTRICT
INCIDENT/ACCIDENT REPORT

Injured's Name: _____ M F Date: _____/_____/_____
Print Clearly Last First Circle One

Parent/Guardian: _____

Address: _____ Birth Date: _____

School: _____ Grade: _____

Date of Incident/Accident: _____ Location: _____ Time: _____

Intramurals Yes ___ No ___, or Interscholastic Sports Yes ____ No ____ ?

What Sport? _____ Signature of Teacher/Coach in Charge: _____*
Required

Name of other witnesses: _____

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**** IF MORE SPACE IS NEEDED PLEASE ATTACH ADDITIONAL SHEETS****

1. Cause of incident/accident: (to be completed by **supervising coach or teacher).** How did it happen? What was the student doing?

2. Result of incident/accident: Description of injury:

3. Action taken: By _____ Signature: _____

A. Parent or other person notified: _____ Time: _____ How?_____

B. Student returned to class at: _____ OR

C. Student was transported to: _____ by:_____

D. Examined by: _____

E. Results of examination: _____

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Original to Superintendent: Copies to Building Principal and Nurse

Revised: 8/20/18plwl
File: Student Accident Insurance/Incident-Accident Report

AIG
Personal Accident Claims Department
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-893-8574 (Facsimile)
AHClaims@AIG.com (Email)

PROOF OF LOSS

UNDERWRITTEN BY: NUFIC

NAME OF GROUP: Crawford Central School District

POLICY NUMBER: SRG 0009145450-A

PERSONAL ACCIDENT CLAIM FORM

INSTRUCTIONS:

1.) You must have SECTION A fully completed by a designated official of the Policyholder.

2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.

NEW YORK FRAUD STATEMENT: 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.

☐ PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

☐ EXCESS PLAN - 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 Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME OF SCHOOL/ORGANIZATION	NAME OF SCHOOL DISCTRICT (IF APPLICABLE)

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. MANDATORY	DATE OF BIRTH	GENDER: MALE ☐ FEMALE ☐

WAS THE ACCIDENT RELATED TO AN ACTIVITY SPONSORED BY THE SCHOOL OR ORGANIZATION ? YES ☐ NO ☐	DATE OF INJURY OR FIRST TREATMENT FOR SICKNESS	IF SICKNESS PROVIDE DATE SYMPTOMS BEGAN

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW (PLEASE PROVIDE ALL DETAILS) AND WHERE ACCIDENT OCCURRED

NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
INDICATE THE SPORT (IF APPLICABLE)	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER

SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE	NAME OF SUPERVISOR

SECTION B - MUST BE COMPLETED

DO YOU HAVE OTHER INSURANCE ☐ **YES** ☐ **NO** | IS THE OTHER INSURACE ONE OF THE FOLLOWING TYPES OF COVERAGE: ☐ GROUP (EMPLOYER) ☐ INDIVIDUAL ☐ GOVERNMENT ☐ MEDICAID

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED. YOU MAY ALSO SEND A COPY OF THE INSURANCE ID:	POLICY # OR ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT	BEST PHONE NUMBER	EMAIL ADDRESS

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE #

I HEREBY AUTHORIZE ANY COMMUNICATION BETWEEN THE POLICY HOLDER AND AIG AND IT'S AFFILIATES IN REGARDS TO THE ABOVE MENTIONED CLAIM AND RELATED MEDICAL EVENTS.

Signature **Date**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and 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 the Insurance Company named above 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.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PERFORMED. ☐ **YES** ☐ **NO**

CLAIMANT OR PARENT/GUARDIAN'S SIGNATURE **DATE**

FRAUD STATEMENTS

FOR USE ON ALL APPLICATIONS AND CLAIM FORMS

ALABAMA: 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.

ALASKA: A PERSON WHO KNOWLINGLY 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.

ARIZONA: FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING 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 CIVIAL PENALTIES.

ARKANSAS, LOUISIANA, RHODE ISLAND, AND WEST VIRGINIA: 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.

CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRADULENT 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.

DELAWARE: 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.

DISTRICT OF COLUMBIA: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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.

INDIANA: A PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

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.

MAINE: 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 A DENIAL OF INSURANCE BENEFITS.

MARYLAND: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURNACE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MINNESOTA: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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 CIVIAL PENALTIES.

NEW MEXICO: 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 CIVIL FINES AND CRIMINAL 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: WARNING: 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.

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 PURPSOSE 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.

TENNESSEE, VIRGINIA, AND WASHINGTON: 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 THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE:	DATE:

CLAIM INSTRUCTIONS

In case of an accident, notify the school/organization immediately.

Step 1: Notify **ALL** treatment facilities (physician's office, hospital, etc.) of this insurance coverage so that any invoices and/or Explanation of Benefits (EOB) can be sent directly from the medical facility to AIG.

Step 2: Have Part I and Part II completed on the Notification of Injury form. Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

Step 3: Attach any itemized bills to the claim form, along with any corresponding Explanation of Benefits (EOB) for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax I.D. number. Balance Due bills are not acceptable. Be sure to attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service. Please Note: Both an itemized bill and EOB (if applicable) must be submitted for claims to be considered for accident medical expense benefits.

Step 4: Mail the Notification of Injury form, along with any other applicable correspondence to our office. Do not leave this form with the school, coach, hospital, physician, etc. When sending information to our office, please use the address below.

AIG Personal Accident Claims
P.O. Box 25987
Shawnee Mission KS, 66225

You may also send electronically; our fax number is 866-893-8574 or e-mail to AHClaims@aig.com

Should you or a provider need to reach AIG for benefit coverage, or claims questions please call 800-551-0824.

Note: If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.