Medical Insurance Services Group
U.S. Specialty Insurance Company (USSIC)
Box No. 2005
Farmington Hills, MI 48333-2005
1-800-605-2282 / 317-262-2132

PARTICIPANT ACCIDENT CLAIM FORM

Policy Name: _____

Policy Number: _____

INSTRUCTIONS

- ✓ **PLEASE FULLY COMPLETE THIS FORM**
- ✓ **ATTACH ITEMIZED BILLS**

FORM SUBMISSION OPTIONS

Paper Form - Mail to:
Tokio Marine HCC - MIS Group
Box No. 2005
Farmington Hills, MI 48333-2005

Email & Fax:
service@hccmis.com
Fax: 317-262-2140

PART I: POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)	**2. Social Security Number**	**3. Gender** ☐Male ☐Female	**4. Date of Birth**	**5. E-Mail**
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)				
7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)				
8. Date and Time of Accident	**9. Place where Accident Occurred**	**10. The injured person was a:** ☐ Participant ☐Staff Member ☐Guest ☐Volunteer		
Dental Claims >	**11. Indicate which Teeth were Involved in the Accident**	**12. Describe Condition of Injured Teeth Prior to Accident:** ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐Artificial		
13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)		**Did Injury Result in Death?** ☐Yes ☐ No		
14. Describe How Accident Occurred – Give All Possible Details (Attach additional pages if necessary)				

15. Did Accident Occur (Check Yes or No for Each of the Following):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?	☐Yes	☐ No
B. On activity premises?	☐Yes	☐ No
C. While on the job (if applicable)?	☐Yes	☐ No
D. While traveling directly and uninterruptedly to or from home and policyholder premises?	☐Yes	☐ No
E. During intercollegiate/scholastic athletic practice?	☐Yes	☐ No

16. Name of Event or Activity	**17. Name of Event or Activity**
18. Name of Policyholder	

19. Signature of Policyholder Representative	**20. Title of Policyholder Representative**	**21. Date**

PART II: OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐Yes ☐ No

If Yes, name of insurance company	**Policy #**
Name of insurance company	**Policy #**
Claimant's primary employer name, address, and phone number	
Mother's primary employer name, address, and phone number	
Father's primary employer name, address, and phone number	

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse U.S. Specialty Insurance Company / HCC Medical Insurance Services., or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT:	**Date:**

PART III: AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health-related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to U.S. Specialty Insurance Company / Tokio Marine HCC - Medical Insurance Services Group. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed. I further certify I have read and signed the Fraud Warning statement listed on the next page of this form.

SIGNATURE OF PARTICIPANT, PARENT OR AUTHORIZED INSURED PERSONNEL:	**Date:**

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FRAUD STATEMENTS

Important Notice

Applicable in Alabama, Arkansas, District of Columbia, Louisiana, New Mexico, 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.

Applicable in 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.

Applicable in 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.

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in Kentucky, Ohio, 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in 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 and denial of insurance benefits.

Applicable in Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Applicable in New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in 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 subjects such person to criminal and civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Oklahoma: 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.

Applicable in Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in 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.

In General and for all other states not previously stated: 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.