



USA Volleyball Incident Report Form Injury or Property Damage

Send this form to:
 Lowell Gratigny
 American Specialty
 142 N. Main Street, Roanoke, IN 46783
 Phone: 260-673-1128 or 800-245-2744
 Fax: 260-673-1291
 lgratigny@amerspec.com

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name	First	Middle	Telephone Number ()	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address			Social Security Number _____	
City _____ State _____ Zip _____		Employer and Address _____		
Age _____ D.O.B _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				
Date of Incident _____ Time of Incident _____ AM/PM		Does the injured person have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name of company and policy #:		
Team Name: _____				
Region: _____		INJURED PERSON: <input type="checkbox"/> Participant <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____		
USAV Membership #: _____				

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name	First	Middle	Telephone Number ()
Address		City State Zip	

INCIDENT INFORMATION

BODY PART INJURED <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Back <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Finger <input type="checkbox"/> Internal <input type="checkbox"/> Head <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> No Injury <input type="checkbox"/> Tooth <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Other	<i>If Ankle Injury, was ankle</i> <input type="checkbox"/> Taped <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported <i>Shoes:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Knee Injury, was knee:</i> <input type="checkbox"/> Braced <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported <i>Knee Pads:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	INCIDENT <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Overexertion <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Property Damage <input type="checkbox"/> Animal/insect bite/sting	
COURT SURFACE <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt <input type="checkbox"/> Grass <input type="checkbox"/> Sand <input type="checkbox"/> Wood <input type="checkbox"/> Sport Court <i>If sport court, what is under-lying surface?</i> <input type="checkbox"/> Wood <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt	INCIDENT LOCATION <input type="checkbox"/> Before Competition/Event <input type="checkbox"/> During Competition/Event <input type="checkbox"/> After Competition/Event <input type="checkbox"/> Competition area <input type="checkbox"/> Concession area <input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area <input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property <input type="checkbox"/> Bleachers/stands	PRIMARY INJURY <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Amputation <input type="checkbox"/> Nausea <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Seizures <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasion <input type="checkbox"/> Sting/bite <input type="checkbox"/> Illness <input type="checkbox"/> Death	DISPOSITION <i>No care given:</i> <input type="checkbox"/> Patient ed refused <input type="checkbox"/> Not needed <i>Released:</i> <input type="checkbox"/> To parent <input type="checkbox"/> To personal vehicle <i>Referral</i> <input type="checkbox"/> To doctor <input type="checkbox"/> To hospital/clinic <i>EMS transport:</i> <input type="checkbox"/> Trainer recommended <input type="checkbox"/> Patient/parent quested

Describe how the injury or property damage occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

Name	Address	Telephone Number
1.		()
2.		()

Tournament Director, Club Director, Coach and/or USA Volleyball Official completing this form:

Name: _____ **Signature:** _____

Title: _____ **Date:** _____ **Phone #:** () _____

Event Name: _____

Event Location & Sanctioning Region: _____

Please provide a copy of this form to the region office which sanctioned the event

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USA Volleyball MEDICAL CLAIM FORM 2010/11 SEASON

Send this form to:
American Specialty
142 N. Main St.
Roanoke, IN 46783
FAX: 260-673-1189

This form to be completed whenever a medical claim results from an injury incurred at USA Volleyball sanctioned events.
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY							
NAME	(Last Name)	(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS	(Street)	(City)	(State)	(Zip Code)	TELEPHONE NUMBER ()	OCCUPATION	
USA VOLLEYBALL PARTICIPANT #:				DATE & TIME OF ACCIDENT: _____ / _____ / _____ AM _____ PM			
INJURED PARTY WAS:							
<input type="checkbox"/> PARTICIPANT <input type="checkbox"/> COACH <input type="checkbox"/> OFFICIAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER: _____ IF PARTICIPANT, MEMBERSHIP TYPE: <input type="checkbox"/> JUNIOR MEMBER <input type="checkbox"/> ADULT MEMBER <input type="checkbox"/> NATIONAL OR HIGH PERFORMANCE TEAM MEMBER							
REGIONAL ASSOCIATION NAME:				COACHES NAME:		PHONE #: ()	
NATURE OF INJURY							
FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:							
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT: _____							
B. DESCRIBE WHERE ACCIDENT HAPPENED: _____							
C. DESCRIBE HOW ACCIDENT HAPPENED: _____							
D. DID THE ACCIDENT OCCUR DURING:							
<input type="checkbox"/> COMPETITION <input type="checkbox"/> PRACTICE <input type="checkbox"/> TRAVELING TO/FROM <input type="checkbox"/> OTHER: _____							
E. WITNESS NAME: _____				PHONE #: _____			
IF INJURED PARTY IS A MINOR:							
PARENT/GUARDIAN NAME: _____				HOME PHONE #: _____			
EMPLOYER NAME: _____				WORK PHONE #: _____			
IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF YES, NAME OF INSURANCE COMPANY						POLICY NUMBER	
ADDRESS	(Street)	(City)	(State)	(Zip Code)			
AUTHORIZATION TO RELEASE INFORMATION							
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.							
NAME OF PATIENT				SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)		DATE	
AUTHORIZATION TO PAY PROVIDER - I authorize payment associated with this incident directly to the physicians or providers.				IF YES, SIGNATURE		DATE	
I certify that the foregoing information is true and correct.				SIGNATURE		DATE	

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.



2010/11 Season USA Volleyball MEDICAL CLAIM FILING INSTRUCTIONS

1. **DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA VOLLEYBALL.**
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital or other providers' standard insurance billing forms: HCFA from physician or UB 92 from Hospital. These forms must show the following:
 - Patients Name
 - Condition/Diagnosis
 - Type of Treatment
 - Date expense incurred
 - Charges
4. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Medicare, Medicaid, Armed Forces or other coverage.
5. To expedite proper processing, submit form complete in full along with the above documents to the following address:

American Specialty
PO Box 459
Roanoke, IN 46783
Phone Number: 800-566-7941 or 260-673-1109
Fax Number: 260-673-1189

E-Mail Address: Adjuster: grudicel@amerspec.com

Important Claim Notice

California Residents: Caution: 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.

Colorado Residents: Caution: 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.

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 Residents: Caution: 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.

Kentucky Residents: Caution: 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 Residents: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Minnesota Residents: Caution: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Caution: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Caution: 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.

Oregon Residents: Caution: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Caution: 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.

Tennessee Residents: Caution: 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 Residents: Caution: 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.

Virginia Residents: Caution: 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.

For All States Other Than Those Above: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Signature of injured person (or parent/guardian if a minor)

Date

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USA VOLLEYBALL

Secondary Sport Accident – Summary of Coverage for 2009-2010 Season
All Domestic Team Participants Competing in Sanctioned USA Volleyball Events

Insurer: National Union Fire Insurance Company of PA
Claims Administrator: American Specialty

What is covered?

Accidental injury that occurs while participating in USA Volleyball sanctioned events.

Who is covered?

All members registered with USA Volleyball including but not limited to athletes, coaches, trainers, volunteers, committee members, and officials while functioning on behalf of or while participating in a sanctioned event.

What are the benefits?

Excess Accident Medical – \$25,000 maximum per injury

Coverage will consider the usual and customary expense for medically necessary care received at a hospital or provided by a licensed practitioner.

Accidental Death & Dismemberment - \$10,000 principal sum

Coverage will consider \$10,000 for the accidental loss of life and \$2,500, \$5,000 or \$10,000 (depending on loss type) for covered incidents resulting in accidental dismemberment. Loss must occur within 100 days after the date of accident.

Is there a deductible?

Yes. The deductible for USA Volleyball's accident medical coverage is \$250 for participants with primary health insurance. This means that the injured person must pay the first \$250 of the medical bill. If primary health insurance is not carried, the deductible is \$1,000.

Does the policy have any restrictions?

- For coverage to apply, the injury must be reported immediately to an official.
- The policy provides coverage against loss in excess of coverage provided under other valid and collectible medical insurance.
- See policy for specific exclusions.
- Claims must be filed within 90 days of treatment.

What is not covered?

- Illness or Sickness
- Re-injury and/or Pre-Existing Conditions
- Injuries caused by wear and tear of overuse, such as tendonitis, bursitis or stress fractures
- Injuries occurring elsewhere than the premises designated for competition
- Suicide or Attempted Suicide
- Fighting, unless as an innocent victim
- Hernias, in any form
- Non-prescription drugs
- Expenses incurred outside the United States

This is only a general summary of coverage and is not intended to attempt to describe all of the plan provisions. Actual coverages are detailed in the policy and are subject to the conditions contained therein.