

Office of Youth Ministry/CYO Athletics
Archdiocese of San Antonio
2718 W. Woodlawn Ave
San Antonio, Texas 78228
(210) 734-1625
Fax (210)735-2695

Accident Report Form To Be Completed

Registration Year **2010-2011**

Full Name	Address (Street, City, State, Zip)	
Date of Birth	Telephone	Parish

Item 1:

Date of Injury	Sport/Position	Location (Gym, Field, Etc.)
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Give full description of injury from which you are suffering, tell **Where, When, And How** it happened.
Full Details Please

Hospital	Address	
Dates of Confinement	From	To

Do you have insurance, including Student Accident Insurance? Yes or No
If yes, which insurance carrier?

To Be Completed By Club Official

Item 2:
I hereby certify that the above is a member of our parish CYO Athletics for the 2010-2011 year and that the above injury was sustained while participating in official CYO activities under adequate organizational supervision.

Name of Parish and Zone _____
Name of Division _____
Injury Occurred during _____ Practice _____ Game _____ Other _____
Coaches Signature _____ Date _____ Telephone _____
Address _____
Parish Presidents' Signature _____ Date _____

CLAIM INSTRUCTIONS

Treatment must commence within 90 days from the date of the accident.

1. In case of an accident, notify the school/organization immediately.
2. 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 The Maksin Group.
3. 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.
4. 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.
5. Mail the Notification of Injury form, along with any other applicable correspondence to our office within 90 days from the date of the accident. Do not leave this form with the school, coach, hospital, physician, etc. Our address is **Maksin Management Corp., P.O. Box 2648, Camden, NJ 08101-2648.** If you need further assistance, feel free to contact Customer Service at **1-800-257-6250.** We will be happy to assist you.

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.

NOTIFICATION OF INJURY

**MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP.
P.O. BOX 2648
CAMDEN, NJ 08101-2648
(800) 257-6250**

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 SRG9110019
FOR OFFICE USE
Reference Number AIC0086780
Coverage Code

FORM MUST BE COMPLETED IN FULL

PART I - ACCIDENT REPORT					
1A. Name of School			1B. Name of School District/Diocese/Association		
2A. Name of Student (Last) (First) (Middle Initial)		2B. Social Security No.	2C. Grade	2D. Birthdate	2E. 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. Was the accident school-related? <input type="checkbox"/> Yes <input type="checkbox"/> No			5B. Is the accident covered under a catastrophic policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6A. Did Accident Occur:			6B. a) Date of Accident		6C. Name of Activity
a) while the claimant was supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No			b) Time		6D. Name and Title of Supervisor
b) during sponsored activity? <input type="checkbox"/> Yes <input type="checkbox"/> No					
c) during programmed hours? <input type="checkbox"/> Yes <input type="checkbox"/> No					
d) on activity premises? <input type="checkbox"/> Yes <input type="checkbox"/> No					
e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities? <input type="checkbox"/> Yes <input type="checkbox"/> No					
7A. _____ Signature of School Officer		7B. _____ Title		7C. _____ 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.		
6A. All other Insurance Company(ies) under which Claimant is insured			6B. Policy Number(s)		6C.		
					<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.		
					<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> 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