



1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO HSR

E-Mail: [NRPAclaims@hsri.com](mailto:NRPAclaims@hsri.com)



HSR Plaza II  
4100 Medical Parkway  
Carrollton, Texas 75007  
Phone: (972) 512-5600 Fax: (972) 512-5820  
Toll Free (866) 345-0975

Adult Team Sports Policy Number:

**PTP N04822432**

League/Team Affiliation: \_\_\_\_\_



**FOR HSR USE ONLY:** Claim Company # \_\_\_\_\_ Plan # \_\_\_\_\_ Location # \_\_\_\_\_

**PART I – POLICYHOLDER’S REPORT**

1. Claimant’s Name (Injured Person)		2. Gender <input type="checkbox"/> M <input type="checkbox"/> F	3. Birthday	4. E-Mail
5. Address of Injured Person				6. Best Contact Phone Number
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		
Dental Claims	10. Indicate which Teeth were Involved in the Accident	11. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
12. Nature of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)			Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident				
14. Did Accident Occur (Check Yes or No for Each of the Following):				
A. While participating as a team member in a scheduled game, official tournament game, or practice session?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
B. During a league/ team meeting or official non-sporting activity?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
C. While traveling directly and uninterruptedly to or from home and policyholder premises?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Activity or Event		16. Name of Policyholder <b>National Recreation and Park Association</b>		
17. Address of Policyholder (Address, City, State, Zip)				
18. Coach’s Signature X		DATE:	19. League Official Signature X	
			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 **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
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**PART III - AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## FRAUD STATEMENTS

**GENERAL:** 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.

**ALASKA, ARKANSAS, IDAHO, INDIANA:** Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

**ARIZONA:** For your protection Arizona law requires the following statement 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 civil penalties.

**CALIFORNIA:** For your protection California law requires the following to appear on this form: 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.

**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 RESIDENTS:** 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.

**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.

**MARYLAND:** 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, commits a fraudulent insurance act.

**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 civil 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.

**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 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.

**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.

**OREGON:** 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:** 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 act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE:** 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.

**VIRGINIA:** 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.



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**PROOF OF ACCIDENTAL DEATH AND BENEFIT APPLICATION**  
(Please print or type except where signature is required)

- 1. Policy Name: NRPA Adult Team Sports
- 2. Policy Number: PTP N04822432
- 3. Name of Insured: \_\_\_\_\_
- 4. Date of Birth: (mm/dd/yyyy) \_\_\_\_\_
- 5. Address of Insured: \_\_\_\_\_  
\_\_\_\_\_
- 6. Social Security Number of Insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- 7. a. Date of Accident: (mm/dd/yyyy) \_\_\_\_\_
- b. Place of Accident: \_\_\_\_\_  
(Town) (Country) (State)
- c. Date of Death: (mm/dd/yyyy) \_\_\_\_\_
- 8. Describe fully how the accident occurred and the nature of injuries received and if motor vehicle involved, whether deceased was operator, passenger or pedestrian.  
\_\_\_\_\_  
\_\_\_\_\_
- 9. Did the death of the insured arise out of or in the course of his or her employment? Yes  No
- 10. Name and Address of Attending Physician(s) \_\_\_\_\_  
\_\_\_\_\_
- 11. a. State the name of the beneficiary: \_\_\_\_\_
- b. State the beneficiary's mailing address: \_\_\_\_\_  
\_\_\_\_\_
- c. Are you the beneficiary described in the certificate and entitled to the proceeds thereof? Yes  No
- d. State your relationship, if any, to insured: \_\_\_\_\_
- e. State your Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

**IMPORTANT! OFFICIAL BOARD OF HEALTH CERTIFICATE OF DEATH MUST BE FURNISHED. ALSO, ATTACH HOSPITAL RECORD AND NEWSPAPER ACCOUNTS, IF OBTAINABLE.**

OVER

I agree that the insurance company shall not be held to admit validity of any claim or waive the breach of any condition of the policy by furnishing this blank and investigating this claim.

Dated at \_\_\_\_\_

X \_\_\_\_\_  
(Beneficiary sign here)

On \_\_\_\_\_, 2\_\_\_\_\_

The signature of the beneficiary must be witnessed, in the space provided below, by a notary public or attorney at law.

\_\_\_\_\_  
(Witness to Signature of Beneficiary)

\_\_\_\_\_  
(Title)

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

(Personalized seal)

\_\_\_\_\_  
Notary Public or Attorney at Law

\_\_\_\_\_  
Print name of Notary Public here

My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

**INSTRUCTIONS**

1. The Company reserves the right to obtain further information should it be deemed necessary.
2. When benefits are payable to the estate of the insured, the Benefit Application must be executed by the executor or administrator and a certificate from proper court indicating the appointment must be furnished.
3. When benefits are payable to a minor, the Benefit Application must be executed by a guardian and a certificate from proper court indicating the appointment must be furnished.
4. When there is no attending physician, a certified copy of the verdict or finding of the coroner or other investigating official is required.
5. If coverage is through a rental car agency, attach a legible copy of the rental agreement.

**MAIL ALL NECESSARY DOCUMENTATION TO:**



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