CHAPTER

3

ATHLETIC INSURANCE

- Procedures
- Forms
- Injury Logs

Cleveland Metropolitan School District

Student Athletic Accident Insurance

Please follow these procedures in order to assure that your claim is promptly and properly handled.

- *Do not hesitate to give the Athlete a Claim Form (***K12 Claim Form***) regardless of the severity of the injury.*
- Family's insurance plan, if any, pays first. CMSD'S policy pays covered medical expenses up to $25,000 of usual customary amounts not recoverable from another medical plan (e.g., if covered in a parent's plan, it pays first).

Principal/Athletic Director

- The Principal/Athletic Director should:
  1. Complete Part 1 – Policyholder's Report
  2. Line #1 Date/ Time/ Place of injury
  3. Line #2 **ONLY CHECK Interscholastic Sports**
  4. Lines #3-7 **Complete all information requested**
  5. Line #8 **Name of event/ Name and title of supervisor = (Coach or Advisor)**
  6. Line #9 **Signed and dated by Principal or designee**

Parent/Legal Guardian

- Athlete's parent/legal guardian must provide information to Principal/Athletic Director including the following:

  1. Complete Part 2 – Other Insurance Statement
  2. Name of Insurance Company
  3. Copies of their Explanation of Benefits from their Insurance or Health Care Plan (***This may be sent in at a later date. It is important to complete and send in the K12 Claim Form as soon as possible).***
  4. Line #10 ***If parent does not have Insurance, they are to sign on line #10.***

MARKEL

Return Completed form to:
Health Special Risk, Inc.
HSR Plaza II; 4100 Medical Parkway
Carrollton, TX 75007
P: 888-765-7223 / F: 972-512-5820
Markelclaims@hsri.com

Special Risk Claim Form

Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number above.

In order to pay claims we must have your Social Security Number

Part 1- POLICYHOLDER'S REPORT

Name of School	Name of Policyholder: Cleveland Municipal School District			Policy Number: 4102AH327010-10
Claimant's Name	Gender: ☐ Male ☐ Female			Date of Birth
Social Security Number (Required)	Email Address			
Claimant's Address	City	State	Zip	Phone Number
Parent's Name (if applicable) / Parent's Address (if applicable)	City	State	Zip	Phone Number

1. Date and time of accident:_____ Place where the accident occurred:_____
2. Was the injured person: ☐ Participant ☐ Staff Member ☐ Guest ☐ Volunteer

FOR DENTAL CLAIMS ONLY

3. Indicate which teeth were involved in the accident:_____
4. Describe condition of injured teeth prior to accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial
5. Nature of Injury:_____
   (indicate part of body injured- e.g. broken arm, sprained ankle, etc.)
6. Describe how the accident occurred- give all possible detailed- must be a bodily injury due to accident:_____
7. Did the accident occur?
   - A. During a policyholder sponsored & supervised activity? ☐ Yes ☐ No
   - B. During programmed hours? ☐ Yes ☐ No
   - C. On activity premises? ☐ Yes ☐ No
   - D. While traveling directly to or from a sponsored event? ☐ Yes ☐ No
   - E. During a USGF sanctioned event (Gymnastics schools only) or competition? ☐ Yes ☐ No
8. Name of the event or activity:_____ Name and Title of Supervisor:_____
9. Representative Signature_____ Title_____ Date:_____

Part 2- OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health coverage through an employer or other source? ☐ Yes ☐ No
If Yes, Name of insurance company_____ Policy #_____
Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐ Yes ☐ No
If Yes, Name of insurance company_____ Policy #_____

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 Markel Insurance Company to the extent of any amount collectible.

Claimant, Parent or Authorized Representative's Signature:_____ Date:_____

ASSIGNMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to the insured.

Claimant, Parent or Authorized Representative s Signature: _____ Date:_____

If Authorized Representative, Relationship to Patient or Legal Designation:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative s Signature: _____ Date:_____

If Authorized Representative, Relationship to Patient or Legal Designation:_____

Incident Report Form

This form should be completed if someone has been injured or property (including motor vehicles) has been damaged.

MARKEL®

P.O. Box 2009, Glen Allen, VA 23058-2009
800-362-7535 Fax: 855-662-7535
newclaims@markelcorp.com

Today's Date: _____ Policy Number: _____

Section I – Insured/Organization Information

Insured/Organization Name: _____

Mailing Address: _____

Location Address (if different than mailing) _____

Phone Number: (_____) _____ Contact Person: _____

Section II – Property Damage Information

Owner of Damaged Property: _____

Address: _____

_____

Phone Number: (_____) _____ Damaged Property Description: _____

_____

Section III – Injured Party Information

Name of the Injured Person: _____

Address: _____

_____

Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Date of Birth: __/__/__

Parent or Guardian (if a minor) _____

Description of injury: _____

_____

_____

Section IV – Incident Information

Date of Damage/Injury: __/__/__ Time of Damage/Injury: _____ a.m. p.m.

1. Exact location of the incident: _____
2. What activity was going on? _____
3. Detailed description of the accident: _____

_____

_____

_____

_____

Please provide the names and information of witnesses:

a. Full Name: _____
Address: _____
_____
Phone #: _____ Age: _____

b. Full Name: _____
Address: _____
_____
Phone #: _____ Age: _____

4. After the incident, what action was taken? **(Please be specific.)** _____
_____
_____

5. If applicable, provide the name of the facility where the injured party was taken: _____

6. How was the injured party transported? _____

7. Who was called? _____ When? _____ a.m. p.m.

Additional Information or Comments: _____
_____
_____
_____

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 the person to criminal [NY residents: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee, and Virginia, insurance benefits may also be denied.

I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

Please provide the following signatures:

_____ _____
Printed Name of the person completing this report Title — Signature of the person completing this report

_____ _____
Printed Name of the supervisor on duty — Signature of the supervisor on duty

_____ _____
Printed Name of the parent/guardian of the injured party (if minor) — Signature of the parent/guardian of the injured party (if available)

Additional Information or Comments: _____
_____
_____

Please fax this completed form to 855-662-7535 or email newclaims@markelcorp.com

PLEASE NOTE:

In furnishing this or other claim forms fro the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

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: Any person who knowingly 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 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.

ARKANSAS: 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 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.

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.

LOUISIANA: 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.

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 or benefit or who knowingly and willfully presents false information in an application for insurance 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 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.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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: 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.

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.

K-12 student accident – public schools

From the blackboard to the ball field, Markel offers a broad range of accident products for K-12 public and private schools. In addition to our "shelf plans," we have the ability and expertise to customize a plan to fit any school's needs.

For more information, contact

Tammy Shrader
Underwriting Technician
804-527-7903
tshrader@markelcorp.com

Coverage options

- **School time:** Covers students while at school and participating in all school-sponsored and supervised activities, except high-schoolfootball.
- **Around the clock:** Extends the school time coverage to include coverage away from school, twenty-four hours a day.
- **Interscholastic football:** All school-sponsored and supervised interscholastic sports are covered under both the school time and around the clock plans with one exception. High-school football coverage must be purchased separately in order for medical expenses arising from practicing or playing to be covered.

Enrollment types

- **Voluntary enrollment:** The school makes the coverage available to parents of all students on a voluntary basis, but does not participate in the individual purchase of insurance.
- **Mandatory/compulsory/blanket enrollment:** School purchases or requires all students to purchase the insurance.

Program specifics

- Accident medical: Limits of $25,000 to $50,000 available
- Accidental death & dismemberment: Limits of $10,000 available
- No deductible

Other coverages

- Short term medical
- Sports camps

Coverage availability varies by state.

Injury Log

- Please keep this form on file for 5 years.

Name	Date of Injury	What was the injury?	Did Athlete See Dr.?	Does Athlete Have Insurance?	Comments

- Copy the release form and keep on file with the injury log.