



Merrimack Youth Association  
PO Box 153  
Merrimack, New Hampshire 03054

## Insurance Coverage

- Merrimack Youth Basketball has insurance coverage for it's participants.
- The coverage is “secondary” unless it is confirmed that there is no other coverage
  - Accident insurance: \$100 deductible, \$25,000 max benefit
  - Secondary insurance will pick up deductibles, co-payments, etc. (after it's own \$100 deductible is met)
  - If used as primary, it will pay up to \$25,000 with a \$100 deductible
- In case of an injury in which medical care is needed
  - First take care of the player!
  - Fill out an Incident Report and get it to your League Coordinator
  - Contact Gagne & Daher Insurance @ 424-8615
  - Complete attached medical claim form



# Incident Report

Merrimack Youth Association  
PO Box 153  
Merrimack, New Hampshire 03054

Type of Incident (circle one): Injury Rule Violation Ejection Sportsmanship Other

Originator: \_\_\_\_\_ Name and phone number \_\_\_\_\_ League: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Location: \_\_\_\_\_ Activity at time of incident: \_\_\_\_\_

Team (s) involved: \_\_\_\_\_ Coach: \_\_\_\_\_

\_\_\_\_\_ Coach: \_\_\_\_\_

Officials: \_\_\_\_\_

**Details** ( be specific, attach separate sheet if necessary)

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**Coordinator Review** (include contact(s), dates, and comments) \_\_\_\_\_ Coordinator name \_\_\_\_\_

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**Disposition:**

Name and position of person closing this item: \_\_\_\_\_

Action: \_\_\_\_\_

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ACCIDENT INSURANCE CLAIM FORM

MAIL TO: NAHGA Claim Services PO Box 189 / 100 Main Street, Bridgton, Maine 04009 1-800-952-4320

Name of Claimant \_\_\_\_\_ Date of Birth \_\_\_\_\_
Current Home Address \_\_\_\_\_
Number and Street City State Zip Code Phone Number

IF CLAIMANT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

Name of Mother \_\_\_\_\_ Name of Father \_\_\_\_\_
Employer Name \_\_\_\_\_ Employer Name \_\_\_\_\_
Employer Address \_\_\_\_\_ Employer Address \_\_\_\_\_
Phone No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Phone No. \_\_\_\_\_ Policy No. \_\_\_\_\_
Group Insurance Co. \_\_\_\_\_ Group Insurance Co. \_\_\_\_\_
Insurance Co. Address \_\_\_\_\_ Insurance Co. Address \_\_\_\_\_
S.S. No. or EE ID No. \_\_\_\_\_ S.S. No. or EE ID No. \_\_\_\_\_

- YES - CLAIMANT IS COVERED BY POLICY
PRIMARY COVERAGE SECONDARY COVERAGE
NO - CLAIMANT IS NOT COVERED BY POLICY

- YES - CLAIMANT IS COVERED BY POLICY
PRIMARY COVERAGE SECONDARY COVERAGE
NO - CLAIMANT IS NOT COVERED BY POLICY

Case of Injury \_\_\_\_\_ Describe Injury \_\_\_\_\_
Describe how and where accident occurred \_\_\_\_\_

Have you suffered some or similar condition before? No Yes if yes, and you were previously treated, dates treated:

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

AUTHORIZATION: I hereby authorize Fairmont Specialty, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and for previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

TO BE COMPLETED BY PROGRAM INSURANCE COORDINATOR
PROGRAM REPRESENTATIVE CERTIFICATION

I hereby certify that the person named above was insured for the activity in which the injury occurred and that the premium was paid prior to the date of injury.

FULL NAME OF ORGANIZATION \_\_\_\_\_ POLICY NO. \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_
Number and Street City State Zip Code PHONE NO. \_\_\_\_\_

PRINTED NAME OF OFFICIAL \_\_\_\_\_ TITLE \_\_\_\_\_

AUTHORIZED SIGNATURE \_\_\_\_\_ PHONE NO. \_\_\_\_\_

### IMPORTANT NOTICE

**Fraud Warning:** Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

**Notice to Arizona Claimants:** 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.

**Notice to California Claimants:** For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

**Notice to Colorado Claimants:** It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or amount payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Notice to Hawaii Claimants:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

**Notice to Idaho Claimants:** Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete, or misleading information is guilty of a felony.

**Notice to Kentucky Claimants:** 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.

**Notice to Oklahoma Claimants:** 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.

**Notice to Pennsylvania Claimants:** 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.

**Notice to Texas Claimants:** 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.

### HOW TO FILE A CLAIM

Please follow these instructions.

- Complete front of claim form, in full;
- Sign Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to NAHGA with itemized bills showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable).

All itemized bills must include:

1. Patient's Name;
2. Patient's Address;
3. Diagnosis;
4. Date of Service;
5. Description of Service (CPT Coding);
6. Medical Provider's Name, Address, Telephone Number, and Federal Tax ID Number.

- A completed claim form must be submitted for each injury a Student sustains

Keep copies of all claims forms, bills and correspondence for your own records.

In order for benefits to be paid, claim forms must be filed within 90 days from the date of injury.