CRUM & FORSTER
A FAIRFAX COMPANY

Please complete this claim form by typing or printing clearly in ink and returning to:

COLE INSURANCE AGENCY
PO BOX 600183, DALLAS, TX 75360-0183
(Phone) 1-214-823-2653 / (Fax) 1-214-823-3805
Email: CSR@coleinsuranceagent.com

The following must be completed, dated and signed by an official of the Organization

Name of Organization (Policyholder)_____ Policy Number_____

Name of Organization of Team (if different from policyholder)_____

Address of Organization _____
Number and Street City State Zip Code Phone No.

Name of Injured Person _____

At the time of injury, was the person involved in an activity under the jurisdiction of the Organization (Policyholder)?

☐ No ☐ Yes If yes, under whose supervision? _____

Was He / She a witness? ☐ No ☐ Yes

Did the injury occur during: ☐ Practice ☐ Travel ☐ Game ☐ Other_____

Date & time of injury_____ Date of 1st treatment_____

Type of Sport or Activity_____

Describe how and where accident occurred: _____

_____

Nature of injury_____

_____

Print Name of Organization Official_____ Title_____

Organization Official's Signature_____ Phone No_____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

NEW YORK FRAUD WARNING: 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.

AUTHORIZATION: I hereby authorize United States Fire Insurance Company or its representative to inspect or secure copies of medical records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous conditions, confinements or disabilities. I further acknowledge that this plan is not subject to the federal regulations commonly known as 'HIPAA'. A photo static copy of this authorization and acknowledgment shall be deemed as effective and valid as the original.
I ALSO ACKNOWLEDGE THE ATTACHED FRAUD WARNINGS

SIGNATURE OF CLAIMANT_____ DATE_____
Or S**ignature of Parent/Guardian if Claimant is 18 years or younger**

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THE FOLLOWING MUST BE COMPLETED BY THE INJURED PERSON OR IF THE INJURED PERSON IS UNDER THE AGE OF 18 OR OTHERWISE DEPENDENT – BY HIS/HER/ PARENT OR GUARDIAN

Claimant's Name _____ SS Number _____
Last Name First Name M.I.

Current Home Address _____
Number and Street City State Zip Code Phone No.

Date of Birth _____ ☐ Male ☐ Female Email address _____

Employer Name _____

Employer Address _____
Number and Street City State Zip Code Phone Nor

PARENT (OR GUARDIAN) INFORMATION (must be completed if claimant is under 18 years of age)

Name of Father or Male Guardian _____ SS Number _____

Current Home Address _____
Number and Street City State Zip Code Phone No.

Employer Name _____

Employer Address _____
Number and Street City State Zip Code Phone No.

Name of Mother or Female Guardian _____ SS Number _____

Current Home Address _____
Number and Street City State Zip Code Phone No.

Employer Name _____

Employer Address _____
Number and Street City State Zip Code Phone No.

Is the claimant covered under any other insurance policy? No Yes

Name of Policyholder _____ ☐ Individual ☐ Group

Name of Carrier _____ Policy No. _____

Carrier's Address _____
Number and Street City State Zip Code Phone No.

Name of Policyholder _____ ☐ Individual ☐ Group

Name of Carrier _____ Policy No. _____

Carrier's Address _____
Number and Street City State Zip Code Phone No.

If other insurance exists, all claims must be submitted to the other insurance policies first. A copy of the itemized bills along with the other carrier's corresponding Explanation of Benefits should be submitted for consideration.