



- 1. PLEASE FULLY COMPLETE THIS FORM
 - 2. ATTACH ITEMIZED BILLS
 - 3. MAIL TO
- E-mail: claims@hsri.com

HSR Plaza
4001 N. Josey Lane
Carrollton, Texas 75007
Phone: (972) 492-6474 Fax: (972) 492-4946

Fraud 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."

POLICY NUMBER: _____ Underwritten by : ACE American Insurance Company

PART I – POLICYHOLDER’S REPORT

1. NAME OF POLICY HOLDER/GROUP		2. ADDRESS OF POLICY HOLDER Street _____ City _____ State _____ Zip _____		
3. NAME OF INSURED PERSON		4. SOCIAL SECURITY NUMBER - -	5. SEX __F __M	6. BIRTHDAY __/__/__
7. ADDRESS OF INSURED PERSON Street _____ City _____ State _____ Zip _____				
8. PARENTS' NAME, ADDRESS AND PHONE NUMBER (INCLUDE AREA CODE)				
9. DATE AND TIME OF ACCIDENT		10. PLACE WHERE ACCIDENT OCCURRED		11. WAS INSURED A PARTICIPANT, STAFF MEMBER, GUEST OR VOLUNTEER?
FOR DENTAL CLAIMS ONLY	12. INDICATE WHICH TEETH WERE INVOLVED IN THE ACCIDENT			
	13. 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			
14. NATURE OF INJURY (INDICATE PART OF BODY INJURED - SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)				
15. DESCRIBE HOW ACCIDENT OCCURRED - GIVE ALL POSSIBLE DETAILS - MUST BE A BODILY INJURY DUE TO ACCIDENT				
16. DID ACCIDENT OCCUR (CHECK YES OR NO) FOR EACH OF THE FOLLOWING:				
A. During a policyholder sponsored & supervised activity?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
B. During programmed hours?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
C. On activity premises?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
D. While on the job (if applicable)?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
E. While traveling directly and uninterruptedly to or from home and policyholder premises?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
F. During intercollegiate/scholastic athletic practice? YES <input type="checkbox"/> NO <input type="checkbox"/>		or competition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G. During a USGF sanctioned event? (Gymnastics schools only)		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
17. NAME OF EVENT OR ACTIVITY:		18. NAME & TITLE OF SUPERVISOR		
19. SIGNATURE OF POLICYHOLDER REPRESENTATIVE X		20. TITLE		21. DATE

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care coverage through your employer or other source on you? 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 your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:
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 **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT X	WITNESS	DATE
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AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a photostatic copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE X	DATE
ADDRESS	