

# INTERCOLLEGIATE SPORTS CLAIM FORM

# MARKEL INSURANCE COMPANY

## HOW TO FILE YOUR CLAIM

1. Complete this form within 90 days.
2. Attach itemized bills
3. Mail to:

**POMCO**  
**PO Box 186**  
**Syracuse, New York 13206**  
**Phone: 866-834-4765**

### NOTICE TO CLAIMANTS:

The Intercollegiate Sports Insurance Plan has been designed to provide maximum benefits for minimum premium. Benefits will be paid for those eligible expenses not paid by your other insurance.

**FLORIDA REQUIRED STATEMENT** - ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NEW YORK REQUIRED STATEMENT** - 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, 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.

## PART 1A: POLICYHOLDER

Policyholder: \_\_\_\_\_ Policy No: \_\_\_\_\_

Address: \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP)

Claimant's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  Male or  Female

Address: \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP)

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_

Where and how did injury occur? \_\_\_\_\_

At the time of injury, was the injured involved in any activity under the jurisdiction of the Policyholder?  Yes  No

Under whose supervision? \_\_\_\_\_ Was he/she a witness? \_\_\_\_\_

Sport participating in at time of injury \_\_\_\_\_

Date medical treatment first received \_\_\_\_\_

Signature:  \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

(Must be signed by an official of the Policyholder)

## PART 1B: STATEMENT OF THE INJURED PERSON

**THIS PORTION OF THE STATEMENT MUST BE FILLED OUT COMPLETELY BEFORE CLAIM CAN BE PROCESSED.**

Have you suffered same or similar condition in the past?  Yes  No If Yes, and you were treated, please give name & address of the physician who treated you: \_\_\_\_\_

Dates treated: \_\_\_\_\_

Claimant's Employer \_\_\_\_\_ Business Phone No. ( ) \_\_\_\_\_

Claimant's Employer's Address \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP)

Spouse's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Business Phone No. ( ) \_\_\_\_\_

Spouse's Employer's Address \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP)

Parent's or Legal Guardian's Employer \_\_\_\_\_ Business Phone No. ( ) \_\_\_\_\_

Parent's or Legal Guardian's Employer's Address \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP)

List ALL OTHER insurance policies. (If no other insurance policies, please indicate.)  Group \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of Other Insurer: \_\_\_\_\_  Individual \_\_\_\_\_ Policy No. \_\_\_\_\_

Other Insurer's Address \_\_\_\_\_ (STREET) \_\_\_\_\_  Other \_\_\_\_\_ Policy No. \_\_\_\_\_

No Other Insurance

(CITY)

(STATE)

(ZIP)

**ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED**  
**EXPLANATION OF BENEFITS FROM OTHER INSURANCE MUST BE ATTACHED**

**AFFIDAVIT:** I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse Markel Insurance Company to the extent for which Markel Insurance Company would not have been liable.

**SIGN:** Claimant, Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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.

**AUTHORIZATION TO RELEASE INFORMATION:** To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit (*while my claim is pending*) the release of any medical information about me to Markel Insurance Company and its representatives. The Company's representatives include Markel Underwriters & Brokers, reinsuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The company will use this information to find out if my claim is eligible. A copy of this authorization (*one of which will be given to me by the Company upon my request*) will be as valid as this one. I certify that the above information given by me in support of this claim is true and correct.

**SIGN:** Claimant, Parent or Authorized Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

If Authorized Representative, Relationship to Patient or Legal Designation \_\_\_\_\_

**PART II - ATTENDING PHYSICIAN'S STATEMENT**  
EACH DOCTOR'S ID OR SOCIAL SECURITY NUMBER

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Nature of sickness or injury. Describe any complications.	
2. If fracture or dislocation, state whether reduced or immobilized. If fracture of long bones, state whether fracture is through shaft or extremity. Was it confirmed by X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. When did symptoms first appear or accident happen?	Date _____, 20__
4. When did patient first consult you for this condition?	Date _____, 20__
5. Has patient ever had same or similar condition? If yes, state when and describe.	<input type="checkbox"/> Yes <input type="checkbox"/> No When? Date _____, 20__
6. Describe any other disease or infirmity affecting present condition.	
7. Give dates of treatment.	
8. Is patient still under your care for this condition? If discharged, give date.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date _____, 20__
9. If patient hospitalized, give name and address of hospital.	HOSPITAL _____ CITY _____ STATE _____ Date admitted _____, 20__ Date discharged _____ 20__
10. Did you file this claim with any other Insurance Company? If yes, indicate name and address of company.	<input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Address: _____

SIGNED: \_\_\_\_\_ DEGREE: \_\_\_\_\_ DATE \_\_\_\_\_

ID OR S.S # \_\_\_\_\_ THIS MUST BE INCLUDED! PHONE NO. ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP)

**IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITION TO THOSE ABOVE.**

1. State exactly which teeth were involved in the accident. \_\_\_\_\_

2. Describe condition of injured teeth prior to accident:  Whole, sound and natural  Filled  Capped  Artificial

**IMPORTANT:** This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment accompanied by all bills incurred to that date.