IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. Accident medical expense coverage under this policy is provided on an Excess Basis and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment.

2. **Claim Guidelines:** You have **90** days from date of injury to submit claim form.
For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.
Benefit Period: This policy is subject to a **365 day** benefit period from date of injury. Medical or dental expenses that are incurred **within 365 days** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **365 day** benefit period will not be covered by this policy.

3. **Please remember:**
   a) Advise your Providers/Hospitals of this insurance so they can file claims directly to OneBeacon.
   b) Attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
   c) **Itemized bills are required**: You must submit itemized bills; balance due bills will not be processed. See below for forms needed.

      1. HCFA-1500- standard form used by Providers
      2. UB-04 or UB-92-standard form used by Hospitals
      3. Payment of bills will follow the **usual and customary guidelines.** This means that the basis for payment of specific medical or dental claims is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to OneBeacon.

For further Claims information contact:

OneBeacon Insurance, Accident & Health Claims
P.O. Box 1009
Morristown, NJ 07962-1009
Phone: 866.583.2233
Fax: 866.638.4418

OneBeacon INSURANCE

Please send the completed form to:
OneBeacon Insurance Company
Accident & Health Claims
P.O. Box 1009
Morristown, NJ 07962-1009
365 day benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

1. **NAME:** (first) _____ (last)_____
2. **ADDRESS**: _____ (city) _____ (state) _____(zip code) _____
3. **TELEPHONE #**:_____
4. **BIRTHDATE:** ___/___/___ **SEX:** Male ☐ Female ☐ Age: _____
5. **CLAIMANT IS A:** ☐ Player ☐ Coa0K ☐ Official Other_____
6. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ am ☐ pm ☐
7. **BODY PART INJURED:**_____ First Date of Treatment: _____
8. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic Other ☐_____
9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____

_____

SECTION II STATISTICAL INFORMATION (required)

1. **NAME OF TEAM/SPORT**:_____
2. **TYPE OF ACTIVITY:** _____
3. **TYPE OF INJURY:** _____
4. **STATUS**: ☐ HIT BY OBJECT ☐ COLLISION W/OPPONENT ☐ Ch[[L{hb W/TEAMMATE

OTHER_____

SECTION III TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL (required)

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER
February 9, 2012	February 9, 2013	43-219900853-12	Dallas Cricket League

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	TELEPHONE NUMBER

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY THE POLICYHOLDER, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT.

☐ YES-SPONSORED/SANCTIONED ACTIVITY
☐ YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

UNDER WHOSE SUPERVISION:_____
WAS HE/SHE A WITNESS: YES ☐ NO ☐

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.		
AUTHORIZED SIGNATURE:	TITLE:	**DATE:**

SECTION IV STATEMENT OF OTHER INSURANCE (required)

Claimant/Father

NAME:_____

ADDRESS:_____

CITY:_____

STATE: _____ ZIP:_____

PHONE:_____

EMPLOYER:_____

PHONE:_____

SELF EMPLOYED ☐ UNEMPLOYED ☐

Claimant/Mother

NAME:_____

ADDRESS:_____

CITY:_____

STATE: _____ ZIP:_____

PHONE: _____

EMPLOYER:_____

PHONE: _____

SELF EMPLOYED ☐ UNEMPLOYED ☐

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES ☐ NO ☐
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES ☐ NO ☐

INSURED NAME: _____ ID#: _____ INSURED GRP#/NAME:_____

COMPANY NAME:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

PHONE:_____

**Please include copy of insurance card (both sides)

Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY:_____

_____

SECTION V ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantial civil penalty to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/CLAIMANT (required): _____ DATE:_____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by OneBeacon Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

CLAIMANT (required): _____ DATE:_____

Please send the completed form to:
OneBeacon Insurance Company
Accident & Health Claims
P.O. Box 1009
Morristown, NJ 07962-1009

Authorization for Release of Information to OneBeacon Insurance Company

Name of Claimant:
Date of Birth:
Social Security Number:

I hereby authorize any health plan, physician, health care profession, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to OneBeacon Insurance Company and its agents, employees, and representative. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

I authorize any insurance company, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Occupational Accident, credit, financial, earnings, activities or employment history to OneBeacon.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to the authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that OneBeacon may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct legally permissible activities that relate to any coverage I have or have applied for with OneBeacon.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OneBeacon Insurance Company at: PO Box 1099, Morristown, NJ 07962. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OneBeacon has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the entire medical record, OneBeacon many not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization. This authorization is intended to comply with the HIPAA Privacy Rule.

*Limits, if any:

Claimant Signature:	Date:	Date of Birth:
	Phone Number:	
Name (Please Print):		
Address:		

IMPORTANT NOTICE

To Alaska Claimants

A 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.

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.

To Claimants in Arkansas, Louisiana, and States Not Specifically Listed in This Notice

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.

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.

To Colorado Claimants

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.

To Delaware Claimants

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.

To Washington, D.C. Claimants

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.

To Florida Claimants

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 of the third degree.

To Indiana Claimants

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.

To Kentucky Claimants

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.

To Maine, Tennessee, Virginia, and Washington Claimants

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.

To Maryland Claimants

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.

To Minnesota Claimants

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

To New Hampshire Claimants

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.

To New Jersey Claimants

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

To New Mexico Claimants

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.

To New York 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 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.

To Ohio Claimants

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.

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.

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