

**National Union Fire Insurance Company**

**PROOF OF LOSS**

MCA Administrators  
 PO Box 6540  
 Harrisburg, PA 17112  
 800-427-9308 (Toll)

<b>NAME OF GROUP:</b>  <b>POLICY NUMBER:</b>
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**SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM**

**INSTRUCTIONS:**

- 1.) **You must have SECTION A fully completed by a designated official of the Policyholder.**
- 2.) **SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.**
- 3.) **Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

<input type="checkbox"/> <b>PRIMARY PLAN</b> - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.	<input type="checkbox"/> <b>EXCESS PLAN</b> - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.
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The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

**SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER**

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
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DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED
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NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).
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NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
INDICATE THE SPORT (IF APPLICABLE)	B. DURING SPONSORED ACTIVITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	C. DURING PROGRAMMED HOURS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE LAST WORKED	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> NO

DATE RETURNED TO WORK	WEEKLY EARNINGS
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POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER ( )
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SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE
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**SECTION B - MUST BE COMPLETED**

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #
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IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER
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NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE # ( )
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**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

**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 group 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 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 authorize payment of medical benefits to the physician or supplier for service performed.  YES  NO

For your protection, California law requires the following to appear on this form:  
 Any person who knowingly presents a 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. For claimants not residing in California, New York, or Pennsylvania: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE	DATE
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