III. CLAIMS ADMINISTRATION

Insurance Providers:

Sport Accident Insurance:
National Union Fire Insurance Company of PA

Liability Insurance:
AXIS Insurance Company

Claims Administration:

American Specialty
Claims Representative Lowell Gratigny
142 N. Main Street, Roanoke, IN 46783
Phone: 260-673-1128
Fax #: 260-673-1291
E-Mail: lgratigny@amerspec.com

Entertainment & Sports Insurance Experts, Inc.
5560 New Northside Drive, Suite 640
Atlanta, GA 30328
Phone: 678-324-3300
800-342-4371
Fax: 678-324-3303

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I) SPECTATOR & PARTICIPANT LIABILITY

A. INFORMATION TO BE OBTAINED BY THE TOURNAMENT DIRECTOR, CLUB DIRECTOR OR COACH

The Tournament Director, Club Director, Coach or USA Volleyball Representative shall obtain and record the information, immediately at the scene of or upon notice of an incident resulting in bodily injury or property damage, to complete the incident report. The USA Volleyball Incident Report form should be completed in its entirety and emailed, mailed or faxed within 48 hours to the Regional Volleyball office who will provide a signed copy to American Specialty. In addition, any claim involving serious bodily injury, death or property damage should be sent immediately to the Regional Volleyball office and to American Specialty. American Specialty will notify ESIX of the claim. These reports must be submitted **as the incidents occur**. See the Directory on page 3 for contact information.

If the appropriate USA Volleyball Incident Report is not available, the following minimum information should be documented and forwarded to the Regional Volleyball office as quickly as possible. Upon receipt of this information the Regional Volleyball office will forward a blank incident report to be completed and returned promptly.

1. Name, address and phone numbers of all individuals involved. Include your name and phone number.
2. A complete description of how the incident occurred from the third party involved and any witnesses, including officials or volunteers, acquainted with the facts.
3. Any other information, which may assist in handling of any potential claim.
4. If the incident involves injury to a participant, a Sport Accident Excess Medical claim form shall be provided to the participant for completion and submittal to American Specialty.
5. The name of the Region in which the incident occurred, including the Club name and Tournament, if the incident occurred during a tournament.

A copy of the incident report should be retained by the Region.

B. REPORT TO ESIX

IMMEDIATELY (Within 24 hours)

Please notify ESIX immediately by FAX or phone of the following:

1. Property damage in excess of $10,000.
2. The receipt of any document/notice of third party liability such as a LAWSUIT or SUMMONS.

All other incidents or claims should be reported within 48 hours.

C. HANDLING OF INCIDENT REPORTS

Club Directors, Coaches, USAV Representatives shall be required to submit incident reports on ALL INCIDENTS that occur that give rise to bodily injury or property damage losses.

Incident Report forms & related correspondence should be submitted to the appropriate party as follows:

Incident report forms should be submitted to the Regional Volleyball office. Medical claim forms should be submitted directly to American Specialty.

When the claim forms have been submitted to American Specialty, they will process the General Liability and Sport Accident claims as appropriate.

a) If American Specialty feels that a liability claim DOES exist, they;

1) Will do preliminary investigation and will establish a reserve, if appropriate.

2) Will take all necessary steps if an actual claim is received.

3) May recommend to USA Volleyball an attorney assignment in the jurisdiction in which the incident occurred.

b) If American Specialty determines that a liability exposure DOES NOT exist:

1) The Claims Representative for American Specialty will log the incident as received and no further action will be taken unless a subsequent claim is filed.

D. INVESTIGATING AND SETTLING OF CLAIMS

American Specialty reserves the right to handle the adjustment of the claim. USA Volleyball and ESIX agree to provide American Specialty with all information which relates to the incident and, when requested, will assist American Specialty in the settlement of the claim.

E. CLAIMS FOLLOW-UP

3. ESIX will update USA Volleyball as to the status of all pending claims on a PERIODIC basis.

4. Any additional documentation, which is received by USA Volleyball and which pertains to liability claims should be mailed to the claims representative at American Specialty with a copy to the appropriate region. In addition, any phone calls, which concern these claims, may be directed to:

American Specialty
Claims Representative: Lowell Gratigny
142 N. Main Street, Roanoke, IN 46783
Phone: 260-673-1128
Fax #: 260-673-1291
E-Mail: lgratigny@amerspec.com

5. Any difficulties or questions, which USA Volleyball may have on the claims process or on specific claim, may also be directed to Jennifer Rains of ESIX for research.

B. **UPON RECEIPT OF ANY DOCUMENT OR NOTICE OF THIRD PARTY LIABILITY (I.E., SUBROGATION DEMAND, REQUEST FOR PAYMENT FROM PARTICIPANT/SPECTATOR, LAWSUIT), USA Volleyball, and its Tournament Directors, Club Directors or Coaches shall FORWARD such document to ESIX IMMEDIATELY.**

ESIX will match this notice of claim to the original USA Volleyball Incident Report and will forward the information to American Specialty to be processed.

III) SPORT ACCIDENT EXCESS MEDICAL COVERAGE

A. MEDICAL CLAIM FORM

1. As soon as possible but not later than 90 days, the injured Participant must complete in its entirety and sign the MEDICAL CLAIM FORM and forward the form to American Specialty. The form is located under **USAVolleyball.Org**.

American Specialty
Attn: Gina Hiner
PO Box 459
Roanoke, IN 46783
Phone: 260-673-1109
Fax: 260-673-1189

B. CLAIMS FOLLOW-UP

ESIX will receive payment updates, as well as claims status information, on all medical claims from American Specialty.

1. ESIX will update USA Volleyball as to the status of all Sport Accident (medical) claims on an ANNUAL basis.

2. Any additional documentation, which is received by USA Volleyball, the Region or Club and which pertains to Sport Accident claims, shall be mailed to the Claims Representative at American Specialty. In addition, any phone calls, which concern these claims, shall be directed to the American Specialty Claims Representative.

3. Any questions regarding the group Sport Accident claim process or American Specialty's service may be directed to Sean Lankie at ESIX.

*****IMPORTANT*****

BEHIND THE "CLAIM REPORTING PROCEDURES" YOU WILL FIND AN INCIDENT REPORT AND A MEDICAL CLAIM FORM.

The Incident Report needs to be completed **each** and **every** time a "bodily injury" or "property damage" loss occurs to a spectator, participant or to the facility itself. Each Tournament Director, Club Director or Coach should be given a supply of these Incident Reports and the forms should travel with them to each practice or event. The Directors and Coaches need to be advised of the importance of completing these reports on behalf of USA Volleyball whenever a bodily injury or property damage incident occurs. The Incident Report will enable USA Volleyball to curtail or prevent fraudulent claims from being paid unnecessarily by matching an Incident Report to each claim for damages submitted. If an Incident Report cannot be matched to a claim, the claims representative will know to more thoroughly investigate the claim to determine if the loss really did arise out of a USA Volleyball event. The ability of USA Volleyball to minimize fraudulent claims will result in retaining the lowest insurance costs possible.

The Medical Claim Form should be provided to any participant who sustains an injury while practicing for or participating in an approved or sanctioned event. Tournament Directors, Club Directors or coaches should keep a supply of these forms on hand at each practice or event. The Medical Claim Form is to be completed by the injured participant and sent directly to American Specialty.

If the claims system works as intended, American Specialty will be in receipt of both an Incident Report from the appropriate Regional Volleyball office describing the incident causing injury and a Medical Claim Form from the injured Participant requesting reimbursement for the medical claim. When they receive both the Incident Report Form and the Medical Claim Form for the same incident, they know there is validity in the claim.

Should you have any questions concerning claims handling, please contact:

Sport Accident-Excess Medical:

Gina Hiner @ American Specialty: 260-673-1109
GHiner@amerspec.com

Liability Claims:

Lowell Gratigny @ American Specialty: 260-673-1128
lgratigny@amerspec.com

USA VOLLEYBALL
INCIDENT REPORT FORM
INJURY OR PROPERTY DAMAGE

Submit this form to:

SUBMIT THIS FORM TO YOUR REGIONAL VOLLEYBALL OFFICE (ADDRESS ABOVE)

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name **First** **Middle**

Telephone Number ( ) ☐ **Single** ☐ **Married**

Address

Social Security Number _____ _____ _____

City _____ **State**_____ **Zip**_____

Age_____ **D.O.B** _____ ___ _____ ☐ **Male** ☐ **Female**

Employer and Address _____

_____

Date of Incident _____ **Time of Incident** _____**AM/PM**

Team Name: _____

Region: _____

USAV Membership #: _____

Does the injured person have other medical insurance? ☐ **Yes** ☐ **No**
If yes, please provide name of company and policy #:
_____

INJURED PERSON: ☐ Participant ☐ Official ☐ Coach
☐ Spectator ☐ Volunteer ☐ Other: _____

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name **First** **Middle**

Telephone Number ( )

Address City State **Zip**

INCIDENT INFORMATION

BODY PART INJURED
☐ Ankle (L/R) ☐ Shoulder (L/R) ☐ Back
☐ Knee (L/R) ☐ Wrist (L/R) ☐ Neck
☐ Nose ☐ Finger ☐ Internal
☐ Head ☐ Eye (L/R) ☐ No Injury
☐ Tooth ☐ Ear (L/R) ☐ Other

If Ankle Injury, was ankle
☐ Taped ☐ Supported
☐ Unsupported
Shoes: ☐ Yes ☐ No

If Knee Injury, was knee:
☐ Braced ☐ Supported
☐ Unsupported
Knee Pads: ☐ Yes ☐ No

INCIDENT
☐ Collision (participant/spectator)
☐ Collision (with object)
☐ Collision (participant/participant)
☐ Collision (spectator/spectator)
☐ Struck by falling/flying object
☐ Caught in, on, between
☐ Animal/insect bite/sting
☐ Slip/Fall
☐ Overexertion
☐ Assault/Sexual
☐ Assault/Non-Sexual
☐ **Property Damage**

COURT SURFACE
☐ Concrete ☐ Asphalt
☐ Grass ☐ Sand
☐ Wood ☐ Sport Court

If sport court, what is under-lying surface?
☐ Wood
☐ Concrete ☐ Asphalt

CLASSIFICATION
☐ Non-injury
☐ Minor injury or illness
☐ Serious injury or illness

INCIDENT LOCATION
☐ Before Competition/Event
☐ During Competition/Event
☐ After Competition/Event☐

☐ Competition area
☐ Concession area
☐ Parking lot
☐ Admission area
☐ Restrooms/locker rooms
☐ Off property
☐ Bleachers/stands

PRIMARY INJURY
☐ Allergy ☐ Dislocation
☐ Amputation ☐ Nausea
☐ Foreign Body ☐ Burn
☐ Laceration ☐ Fracture
☐ Heat Exhaustion ☐ Pain
☐ Hypertension ☐ Cardiac
☐ Cold Injury ☐ Contusion
☐ Electrical Shock ☐ Seizures
☐ Strain/Sprain ☐ Concussion
☐ Abrasion ☐ Sting/bite
☐ Illness ☐ Death

DISPOSITION
No care given:
☐ Patient refused
☐ Not needed
Released:
☐ To parent
☐ To personal vehicle

Referral
☐ To doctor
☐ To hospital/clinic

EMS transport:
☐ Trainer recommended
☐ Patient/parent quested

Describe how the injury or property damage occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

Name	Address	Telephone Number
1.		( )
2.		( )

Tournament Director, Club Director, Coach and/or USA Volleyball Official completing this form:

Name: _____ **Signature:** _____

Title: _____ **Date:** _____ **Phone #:** (_____)_____

Event Name: _____

Event Location:_____

Sanctioning Region:_____ **Region Signature:**_____

Region Use Only: For processing, please submit this form to: American Specialty, Lowell Gratigny, Post Office Box 459, Roanoke, IN 46783; Phone: 260-673-1128 or 800-245-2744; Fax: 260-678-8835; Email: lgratigny@amerspec.com

USA VOLLEYBALL
MEDICAL CLAIM FORM
2012-2013 Season

SEND THIS FORM TO:
American Specialty
Post Office Box 459
Roanoke, Indiana 46783
(800) 566-7941 Fax: 260-672-8835
ghiner@amerspec.com

This form should be completed whenever a medical claim results from an injury incurred at USA Volleyball sanctioned events.

PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY

NAME (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)

TELEPHONE NUMBER ( )	OCCUPATION
USA VOLLEYBALL PARTICIPANT #:	DATE & TIME OF ACCIDENT: _____/_____/_____ _____ ___ AM ___ PM

INJURED PARTY WAS:
☐ PARTICIPANT ☐ COACH ☐ OFFICIAL ☐ VOLUNTEER ☐ OTHER: _____

IF PARTICIPANT, MEMBERSHIP TYPE:
☐ JUNIOR MEMBER ☐ ADULT MEMBER ☐ NATIONAL OR HIGH PERFORMANCE TEAM MEMBER

REGIONAL ASSOCIATION NAME:	COACHES NAME: PHONE #: ( )

NATURE OF INJURY

FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT:

_____

B. DESCRIBE WHERE ACCIDENT HAPPENED:

_____

C. DESCRIBE HOW ACCIDENT HAPPENED:

_____

D. DID THE ACCIDENT OCCUR DURING:

☐ COMPETITION ☐ PRACTICE ☐ TRAVELING TO/FROM ☐ OTHER: _____

E. WITNESS NAME: _____ PHONE #: _____

IF INJURED PARTY IS A MINOR:

PARENT/GUARDIAN NAME: _____ HOME PHONE #:_____

EMPLOYER NAME: _____ WORK PHONE #:_____

IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? ☐ YES ☐ NO

IF YES, NAME OF INSURANCE COMPANY	POLICY NUMBER

ADDRESS (Street) (City) (State) (Zip Code)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.

NAME OF PATIENT	SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)	DATE
I certify that the foregoing information is true and correct.	SIGNATURE	DATE

The completion of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.

USA Volleyball
MEDICAL CLAIM FILING INSTRUCTIONS

1. **DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA VOLLEYBALL.**
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital or other providers' standard insurance billing forms: CMS-1500 from physician or UB-04 from Hospital; These forms must show the following:
   - Patients Name
   - Condition/Diagnosis
   - Type of Treatment
   - Date expense incurred
   - Charges
4. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Medicare, Armed Forces or other coverage.
5. To expedite proper processing, submit form complete in full along with the above documents to the following address:

American Specialty
Post Office Box 459
Roanoke, Indiana 46783
Phone Number: 260-673-1109 Fax Number: 260-672-8835
E-Mail Address: Adjuster: GHiner@amerspec.com

IMPORTANT CLAIM NOTICE

Alaska: 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.
Arizona: 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.
Arkansas or Louisiana: 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.
California: 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.
Colorado: 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.
Delaware: 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.
District of Columbia: 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.
Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
Indiana: 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.
Kentucky: 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.

Maine, Tennessee or Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and a denial of insurance benefits.

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

New Hampshire: 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.

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

New Mexico: 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.

New York: 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. (PURSUANT TO 11 NYC RR86)

Ohio: 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.

Oklahoma: 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.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Texas: 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.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

_____ _____

Signature of injured person (or parent/guardian if a minor) Date