Cambridge Administrators
5832 South 142nd St, Suite A
Omaha, NE 68137
Toll Free: (855) 868-7554 Fax: (402) 504-6447
Email: info@CambridgeAdministrators.com

Instructions for Submitting a Blanket Accident Claim

1. This claim form must be submitted for each individual accident/sickness. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/sickness. The claim form must be submitted for each accident/sickness within 90 days of the occurrence.

2. Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan, they must first submit the claim to the primary insurance. Once the primary insurance has processed the charges, the provider should submit the Explanation of Benefits (EOBs) from the primary insurance to us at the address listed below along with the itemized bills (noted in number 3).

3. Please ask your provider to submit all medical bills. The bills must be itemized for service. A physician's office should submit an invoice utilizing a CMS 1500. A hospital and/or emergency room should submit an invoice utilizing a UB04 (CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital). If the provider will not submit the bill(s) directly, please request these forms from the provider(s), include a copy of the primary insurance EOB, and submit to us at the address below. A balance due or patient statement is not acceptable and will only delay processing.

4. In the event that a claim is not submitted in full, or if additional information is needed, the claim will be marked incomplete and the additional information will be requested via US Mail. Please forward the requested information immediately so that we may finish adjudicating your claim in a swift manner. The explanation of benefits form advising what is needed will be sent to the address of the claimant listed on the claim form.

Claim Submission Checklist

Use the checklist below to assure a properly submitted medical claim is being sent:

☐ Is part A of the claim form completed in full by a policyholder official or staff member and signed?

☐ Is part B of the claim form completed in full by the claimant and signed?

☐ If bills are attached, are they in either a CMS 1500 or UB04 form?

☐ If the claimant has primary health insurance, has the claim been submitted first to the primary health insurance?

☐ If claim has first been submitted to the primary health insurance coverage, are copies of primary insurance EOBs (explanation of benefits) attached?

☐ If any payment has been made by the patient, proof of payment must be included or payment will be made to the provider (doctor or hospital).

Send all information to:

Cambridge Administrators
5832 South 142nd St, Suite A
Omaha, NE 68137

Blanket Accident Insurance
Accident Claim Form

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) and/or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

MAILING THE CLAIM

Mailing the Claim
When completed in full, mail the attached completed claim form, itemized medical bills, and copies of EOB's (explanation of benefits, for use if coverage is excess) to:

Cambridge Administrators, LLC
5832 S 142nd St, Suite A
Omaha, NE 68137

Should you have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at **(855) 868-7554**.

Documents may also be faxed to the claims office at **(402) 504-6447**. Please do not fax full medical claims, as often times medical bills are illegible when faxed. For emailing documents, please email **info@cambridgeadministrators.com**

PLEASE NOTE: Claim Forms Must Be Submitted Within 90 Days Of The Date Of Accident.

PART A – This part MUST be completed, dated, and signed by an official or the Organization

1. Name of Organization and Policy Number
USA Youth & High School Rugby PAI L259020171701

2. Address of Organization (Street) (City) (State)
700 Pennsylvania Ave SE Fl 2 Washington DC 20003

3. Name of Injured Person (Insured) (First) (Middle) (Last)

4. Date of Accident/Injury Month Day Year / /	5.Injury Occurred during Practice ☐ Game ☐ Clinic ☐ Other ____	6. Type of Sport/Activity
7. Explain how the accident and injury occurred as well as the body part injured. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.		7a. Indicate if the Practice, Game or Clinic noted in #5 above was: ☐ Contact Event ☐ Non-contact Event

8. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐	9. Name of Supervisor of Activity	10. Was he/she a witness? Yes ☐ No ☐

11. Signature of Organization Official	12. Title of Official	13. Telephone Number	14. Date Signed
X ____		( )	

PART B – This part MUST be completed, dated, and signed by the Injured Person, or by Injured Person's Parent or Guardian if he/she is under age 18 or otherwise dependent

Print Name of Person Completing Form   Check one: ☐ Injured Person ☐ Parent ☐ Guardian

Please provide the following information about the Injured Person:

1. Date of Birth Month Day Year / /	2. Gender ☐ Male ☐ Female	3. Social Security No. or Student Visa No. / /	4. Telephone Number ( )

Please note the Injured Person's Social Security # MUST be provided, as required by the Center for Medicare Services.

5. Address (Street) (City) (State)

6. Employer Name (Street) (City) (State)

Employer Telephone Number ( )

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ☐ No ☐
If YES, please provide the following:

Name of Other Insurance Company (ies)	Address of Other Insurance Company (ies)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, please provide the following:

Name of Father or Male Guardian   Place of Employment

Address of Employer   Employer Phone Number ( )

Name of Mother or Female Guardian   Place of Employment

Address of Employer   Employer Phone Number ( )

9. If the Injured Person is married, please provide the following:

Name of Wife/Husband   Place of Employment

Address of Employer   Employer Phone Number ( )

Authorization to Release Medical Information:
I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company, or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In CA, CT, GA, HI, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I understand that my authorized representative or I will receive a copy of this authorization upon request.

Warning: 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. (Fraud language varies by state, for **New York** see the following, all other state specific states, please see below)

For residents of 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.

☐ Injured Person ☐ Parent ☐ Guardian

Name of Responsible Party: ____

Signature of Responsible Party: ____ Date: _________________

FRAUD WARNING NOTICES

For residents of 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.

For residents of 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.

For residents of 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of 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.

For residents of 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.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

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

For residents of 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.

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

For residents of 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.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.