COMPLETE AND RETURN THIS FORM TO:

Medical/Dental Accident CLAIM FORM

RPS BOLLINGER SPORTS & LEISURE INSURANCE

MARKEL®

P.O. Box 1322, Morristown, NJ 07960

52-week 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☐ SS#:_____
5. **CLAIMANT IS A:** ☐ Player ☐ Coach ☐ Official ☐ Other
6. **ACCIDENT DATE:** __/__/__ **ACCIDENT TIME:**_____ ☐ am ☐ pm
7. **BODY PART INJURED:**_____
8. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Other_____
9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____
10. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURED:**_____

SECTION II STATISTICAL INFORMATION (required)

1.NAME OF TEAM/CLUB:_____

2. TYPE:	☐ Competitive	☐ Recreational		
3. LOCATION:	☐ On Field	☐ Indoor	☐ Spectator Area	☐ Other
4. SURFACE:	☐ Dirt	☐ Grass	☐ Outdoor Turf	☐ Indoor Turf
5. SURFACE CONDITION:	☐ Dry/Normal	☐ Wet/Rainy	☐ Icy	☐ Muddy

6. POSITION: _____

7. STATUS: ☐ HIT BY OBJECT ☐ COLLISION W/OPPONENT ☐ COLLISION W/TEAMMATE

☐ OTHER_____

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

Policy Effective Date	**Policy Expiration Date**	**Policy #**	**Name of Policyholder**
07-21-2024	07-21-2025	4102AH011763 - 5	Elite Alliance Volleyball Club

ADDRESS OF POLICYHOLDER (Street)	(City) (State)	TELEPHONE NUMBER
700 16th St. NE	Watertown, SD 57201	

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

☐ YES-SPONSORED/SANCTIONED ACTIVITY

☐ YES-CLAIMANT WAS AN ACTIVE MEMBER ON THE DATE OF ACCIDENT

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 Code:_____
Phone:_____
Employer:_____
Phone:_____
Self Employed ☐ Unemployed ☐
Email: _____

Claimant/Mother

Name:_____
Address:_____
City:_____
State:_____ Zip Code:_____
Phone:_____
Employer:_____
Phone:_____
Self Employed ☐ Unemployed ☐
Email:_____

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**

POLICYHOLDER NAME: _____ **ID#:** _____

INSURED GRP#/NAME: _____

INSURANCE 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 (required)

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING PROVIDED INDICATES PAYMENT MADE BY YOU.

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

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (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 RPS Bollinger or Markel Insurance Company or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

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