Young Marines

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. SEND TO: →

Underwritten by: ACE American Insurance Co.
POLICY NUMBER: PTPNOO719936

HSR
Health Special Risk, Inc.
HSR Plaza
4001 N. Josey Lane
Carrollton, TX 75007
Phone: (972) 492-6474 Fax: (972) 492-4946
Email: claims@hsri.com

FRAUD WARNING: ^/š]• Œ]u š} ‰Œ misleading information to an insurer for the purpose o defrauding the insurer or any other person. Penaltie include imprisonment and/or fines. In addition, ar insurer may deny insurance benefits if false informatio materially related to a claim was provided by the ‰‰o] See attached for a complete list of fraud statements by state.

PART I tWK>/ z,K> Z[^ Z WKZd

1. NAME OF POLICY HOLDER:	2. ADDRESS OF POLICY HOLDER:
YOUNG MARINES	Street: ***P.O. BOX 70735, SW STATION*** City: ***WASHINGTON*** State: ***DC*** Zip: ***20024-0735***

TO BE COMPLETED BY CLAIMANT

3. NAME OF INSURED PERSON	4. SOCIAL SECURITY NUMBER	5. GENDER	6. BIRTHDATE
		F M	

7. ADDRESS OF INSURED PERSON
Street City State Zip

8. NAME OF PARENT/GUARDIAN (IF CLAIMANT IS A MINOR)	AREA CODE TELEPHONE NUM ( )

9. DATE AND TIME OF ACCIDENT	10. PLACE WHERE ACCIDENT OCCURED	11. WAS INSURED PARTICIPANT, STAFF MEMBE GUEST OR VOLUNTEER?

FOR DENTAL CLAIMS ONLY

12. INDICATE WHICH TEETH WERE INVOLVED IN ACCIDENT
13. DESCRIBE CONDITION OF INJURED TEETH PRIOR TO ACCIDENT:
☐ WHOLE, SOUND AND NATURAL ☐ FILLED ☐ CAPPED ☐ ARTIFICIAL

14. NATURE OF INJURY (INDICATE PART OF BODY INJURED, SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)

15. DESCRIBE HOW ACCIDENT OCCURRED, GIVE ALL POSSIBLE DETAILS. THERE MUST BE A BODILY INJURY DUE TO ACCIDENT

16. DID ACCIDENT OCCUR (CHECK YES OR NO) FOR EACH OF THE FOLLOWING:		
A. During a policyholder sponsored & supervised activity?	YES ☐	NO ☐
B. During programmed hours?	YES ☐	NO ☐
C. On activity premises?	YES ☐	NO ☐
D. While on the job (if applicable)?	YES ☐	NO ☐
E. While traveling directly and uninterruptedly to or from home and policyholder premi	YES ☐	NO ☐

17. NAME OF EVENT OR ACTIVITY:	18. NAME & TITLE OF SUPERVISOR

19. SIGNATURE OF POLICYHOLDER REPRESENTATIVE X	20. TITLE	21. DATE

PART II - OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care coverage as the Claimant enrolled as an individual, employee or dependent member of a H Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on your or does your son/daughter have health care coverage as a dependent from your previous marriage as mar in a divorce decree? ☐ YES ☐ NO

If Yes, Name of Insurance Company: _____ Policy # _____

Name of Second Insurance Company: _____ Policy # _____

Coverage is Excess of All Other Insurance and Healthcare Plans in Force

This policy is excess to any and all other available source of medical insurance or other healthcare benefits. You must file your bills through your primary/personal insurance carrier or healthcare plan prior to this policy responding. When your primary insurance company or healthcare plan ‰Œ}••• šZ Z ŒP•U šZ Ç Á]oo•v Ç}µ v Æ‰o v š]}v}(v ()š•U }Œenefits along with your claim to Health Special Risk, Inc. In the event you have no other primary insurance or healthcare plan, this policy will pay as primary subject to the plan limits and terms.

Please read & sign below: I agree that should it be determined at a later date there is insurance (or similar), to reimburse ***HEALTH SPECIAL RISK, INC.***, or the insurance company to the extent of any amount collectible.

SIGNATURE OF CLAIMANT (Parent or Guardian, if Claimant is a Minor) X	WITNESS	DATE

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

(Must Be Completed By Claimant, Or Guardian If Claimant Is A Minor)

I, the undersigned authorize any hospital or other medical institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all informatio 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 basi o]u v }‰]•}(oo šZ š ‰Œ•v[•Z}•‰]šo }Œu] o Œ }Œ •U]v of drugs and alcohol. I authorize payment of benefits under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial a employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a photostatic copy of this authorization sh considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I understand that I or my authorized representative ma revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke. I authorize medical payments to physician or supplier services described on any attached statements enclosed.

SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE X	DATE

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FRAUD STATEMENTS

General: 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.

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, Louisiana, Maryland, West Virginia: 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 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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: 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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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: 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 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 foe each such violation.

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.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

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

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.

HOW TO SUBMIT A CLAIM

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be complete in full and submitted to Young Marines National Headquarters for approval within 90 days from the date of injury. Be sure to answer and complete the section regarding **"OTHER INSURANCE STATEMENT"**, marking either YES or NO and signing the line for authorization so that HSR and the doctors/hospitals may communicate concerning the claim. **Submitting an incomplete claim form is one of the most frequent reasons why claim payments are delayed.**
2. The completed claim form must be sent to YMNHQ to be signed by a policyholder representative. Send the claim form to:

   Young Marines National Headquarters
   17739 Main Street, Suite 250
   Dumfries, VA 22026-3256
   Fax: (202) 315-6594
   Email: patriciaborka@youngmarines.com
3. Only one claim form for each accident needs to be submitted.
4. Once completed, YMNHQ will return the signed form to the claimant, make a photocopy for personal records and ***send to HSR as indicated below***. Be sure to include copies of Injury Report Form (YMMEDFORM7) and Attending Physician's Report (YMMEDFORM8.)
5. **DO NOT** assume that anyone else will send this claim form to ***HSR*** for the claimant.

EXCESS INSURANCE

This policy is excess to any other available source of medical benefits. This means that all bills must be filed through the patient's primary, or personal, insurance carrier prior to this policy responding. When your primary insurance company processes the charges, they will send you an Explanation of Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE to ***HSR***.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward their adjusted itemized bills to ***HSR***.
2. If the subject of this claim has already been to the doctor/hospital and did not know about this coverage, please send all adjusted itemized bills received to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date patient was seen by the doctor/hospital, what the patient saw the doctor for and the specific itemized charges incurred.
4. If this information is not on the bill when it is submitted, HSR will be required to contact the doctor/hospital which will delay the review of this claim. "Balance Due" statements do not contain sufficient information to complete this claim. Sending ***HSR*** "Balance Due" statements will only delay the processing of this claim.

If there are any questions regarding this claim, please contact HSR Customer Service from 8:00 AM thru 5:00 PM CST, Monday – Friday at (800) 328-1114 or via e-mail at claims@hsri.com. All additional documents and/or bills received after this claim submission are to be sent to ***HSR*** via email at claims@hsri.com, fax to (972) 512-5818, or mail to the address below.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007