IMPORTANT NOTICE:
This insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

Health Special Risk, Inc.

HSR Plaza II 4100 Medical Parkway Carrollton, Texas 75007 Phone: (972) 512-5600 Fax: (972) 512-5820 Toll Free (800) 328-1114 **Policy Name: Policy Number:**

3. MAIL OR EMAIL TO HSR E-mail: claims@hsri.com

1. PLEASE FULLY COMPLETE THIS FORM 2. ATTACH ITEMIZED BILLS

PART I - POLICYHOLDER & INSURED				
1. Promoter/Team/League Name		2. Policy Number/Class Code		
3. Claimant - Last Name, First Name		4. Claimant Social Security Number		
5. Mailing Address where Insurance Info/Requests should be mailed		6. City, State, Zip		
7. Birthdate	8. Male 🗖 Female 🗖	9. Phone	10. Email	
	INJURY - Please Complete this Sectio	n to report an Injury	•	
11. Date of Injury 12. Time & Address where occurred?			13. Part of body injured	
14. How did injury occur (description of incident)?			15. Date of first medical treatment	
16. Type of Sport (if applicable):		17. Sport Designation: ☐Practice ☐	Game Event Other	
18. Action Taken: Released to Parent Ambulance Transport Referred to Hospital/Clinic Own Accord (Adult)				
19.Claimant Designation: Coach/Manager Volunteer Participant Umpire/Referee Other				
20.Was the claimant supervised when injured?	es 🗆 No 🗖	No □ 21.Was injury during travel to or from scheduled activity in a supervised group? Yes □ No □		
22.Signature of Policyholder: Date				
PART II — PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)				
1. Father/Guardian Name 9.Mot		9.Mother/Guardian Name		
2.Home Address (Street, City, State, Zip)		10.Home Address (Street, City, State, Zip)		
3.Telephone 4.	Email	11. Telephone	12. Email	
5. Employer		13. Employer		
6.Father's Employer Address (Street, City, State, Zip)		l 4.Mother's Employer Address (Street, City, State, Zip)		
7. Business Phone		15.Business Phone		
8. Employer Medical Insurance Policy (8a) Policy Number:		16.Employer Medical Insurance Policy Address:		
(8b) Is Claimant covered under that policy? Yes \(\sigma \) No \(\sigma \) (8c) Is Claimant covered under that policy? Yes \(\sigma \) No \(\sigma \)				
PART III — INSURANCE VERIFICATION				
ls Claimant covered by any other insurance policy (other than this policy), either as a dependent, group, individual, automobile medical or liability? Yes 🔲 No 🖵				
If yes, Policy Number: Name of Insurance Carrier:				
Address of Insurance Carrier: Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.				
rieuse note that it other insurance exists, all claims most be submitted to that other insurance policy tirst.				
I hereby authorize any hospital, policyholder, physician, employer, or other person who has attended or examined the Claimant to disclose when requested to do so, any information to HSRI CLAIMS or POLICYHOLDER with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A copy of this authorization shall be considered as valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to				
X				
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) AUTHORIZATION TO DAY RENEGETS TO REQUIRED. It has been written in a great the control of a provider of of a provide				
AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.				

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.