Sport Event Registration Cancellation Claim Form

SECTION D – ILLNESS / INJURY STATEMENT – TO BE COMPLETED BY PATIENT
(REQUIRED IF REASON FOR CANCELLATION IS SICKNESS/INJURY)

Name of Person Having Sickness or Injury _____

Date of Birth _____ (MM/DD/YY) Relationship to Policyholder _____

Date Sickness or Injury Began _____ (MM/DD/YY) Date Ended _____ (MM/DD/YY)

Nature of Sickness or Injury (if injury, describe accident, including date and place) _____

_____

If hospitalized, please provide the period of hospitalization:

From _____ (MM/DD/YY) To _____ (MM/DD/YY)

Authorization for Release of Medical Information

(Co-Ordinated Benefit Plans herein referred to as the "Administrator")

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Berkley Group Companies (Berkley Life and Health Insurance Company or StarNet Insurance Company), its authorized Administrator or their legal representative, and any agent acting on their behalf any such information.

I understand that I may revoke this authorization at any time by providing written notice to Berkley Group Company or its authorized Administrator. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization. The revocation may not take effect before the date received by Berkley Group Company or its authorized Administrator.

A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I acknowledge that I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

I understand that the authorized Administrator may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by the authorized Administrator in accordance with federal or state law.

Signature _____ Date _____ (MM/DD/YY)

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SECTION E – PHYSICIAN'S STATEMENT – TO BE COMPLETED BY PHYSICIAN

The Physician's Statement is mandatory for claims being considered on the basis of Sickness or Injury. Failure to provide this information may result in a processing delay or closed/denial of your claim

If treatment received outside the United States, please send medical report in place of this form.

Name of Physician _____ Address _____

Office Phone Number _____Fax Number _____

Name of Patient _____ Date of Birth _____
MM/DD/YY

Date symptoms first appeared or accident occurred _____ Date First Treated _____
MM/DD/YY MM/DD/YY

Provide diagnosis and all other treatment dates: _____

Was patient treated by any other physician? ☐ Yes ☐ No

If so, by whom? _____ When? _____
MM/DD/YY

If the patient is the participant, was the patient advised not to attend the event for which they are making a claim? ☐ Yes ☐ No If yes, please advise the dates the patient was unable to participate in the sports event. _____ to _____

Was the patient's condition life-threatening? ☐ Yes ☐ No Did the patient require hospitalization? ☐ Yes ☐ No

If so, Period of Hospitalization: From _____ To _____
MM/DD/YY MM/DD/YY

Name and Address of Hospital _____

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 day period immediately prior to the Effective Date of the Policy noted above in Section B? ☐ Yes ☐ No

If so, please provide exact dates (MM/DD/YY) and provide details _____

Important Notice: 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.

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.

(Fraud language varies by state, for additional state specific fraud warning language, please see below)

Physician Signature _____ Date Completed _____
REQUIRED MM/DD/YY

Please provide authentication of physician signature – physician stamp, physician credentialing information, letterhead of practice or other form of authentication