PART B — This PART **MUST** be **completed, dated** and **signed** by the Injured Person — or if the Injured Person is under age 18 or otherwise dependent — by his/her Parent or Guardian.

PRINT HERE — NAME OF PERSON COMPLETING FORM — Check one: Injured Person ❑ Parent ❑ Guardian ❑

Give the following information about the Injured Person:

1. Date of Birth Mo Day Year / /	2. Male ❑ Female ❑	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ( )

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

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

Area Code/Employer Telephone No.
( )

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

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

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

Name of Mother or Female Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

9. If the Injured Person is married, give the following information:

Name of Spouse — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

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 to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Capitol Insurance Companies 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 application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that I or my authorized representative will receive a copy of this authorization upon request.

X ______________________ Signature (in writing) of Responsible Party

______________________ Print Name

Check one: ❑ Injured Person ❑ Parent ❑ Guardian

Date: __________

NOTIFICATION OF INJURY

Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

This Notification of Injury Form is to be used for accident medical claims.

Policies With Excess Coverage

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 insurance or medical payment plan they must first submit claim to the primary insurance first. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Deductible

If the claimant is paying the deductible prior to submitting any claims for processing, please complete the back of this form. This will ensure that we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

Claim Form

This Company claim form must be submitted for each individual claim. Part (A) must be completed in full and signed by the Policyholder official or a staff member. Part (B) must be completed in full and signed by the injured person or the parent or guardian if the injured person is a minor. A full completed claim form is not necessary when submitting additional medical bills, only one claim form is needed per accident/injury.

Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per HCFA 1500. A hospital and/or emergency room should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be suspended, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish processing your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary? ______

If claim has first been submitted to the primary, are copies of EOB's (explanation of benefits) attached? ______

Is part (A) of the claim form completed and signed by the Policyholder official or staff member? ______

Is part (B) of the claim form completed and signed by the injured person? ______

Are the attached medical bills itemized in either a HCFA 1500 or UB92 form? ______

Is part (B), item number 3 (social security number) completed?

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

Capitol Indemnity Special Risk Accident Medical Claims
P.O. Box 13815
Reading, PA 19612-3815

If you should 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 (866) 340-7181.

Documents may also be faxed to the claims office at (630) 665-7294. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, claim forms should NOT be submitted prior to seeking medical treatment. Please submit this form at the time the itemized bills and explanations of benefits are available for reimbursement.

ACCIDENT DEDUCTIBLE CREDIT SHEET

INJURED'S NAME ____________________

POLICYHOLDER'S NAME ____________________

DATE OF INJURY ____________________

NAME & ADDRESS CHECK SHOULD BE SENT TO:

____

____

____

PROVIDER	DATE OF SERVICE	$ AMOUNT APPLIED TO DEDUCTIBLE
		$
		$
		$
		$
		$
		$

If the claimant is paying the deductible prior to submitting any claims for processing, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

NOTICE

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 may be guilty of a crime and may be subject to civil fines and criminal penalties. California Residents: 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."

PART A — This PART **MUST** be **completed, dated** and **signed** by an official or the Organization.

1. Name of Organization (Policyholder)

2. Policy No.

3. Name of Organization or Team (if different from Policyholder)

4. Address of Organization (Street) (City) (State) (Zip)

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

6. Date of Accident/Injury Mo Day Year / /

7. Injury Occurred: Practice ❑ Travel ❑ Game ❑ Other ____________________

8. Type of Sport or Activity:

9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.

10. Describe the nature of injury.

11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ❑ No ❑

12. Name of Supervisor of Activity

13. Was he/she a witness to the accident Yes ❑ No ❑

14. Signature of Organization Official X ____________________

15. Title of Official

16. Area Code/Telephone No. ( )

17. Date Signed