

INTERCOLLEGIATE SPORTS CLAIM FORM

MARKEL INSURANCE COMPANY

HOW TO FILE YOUR CLAIM

- 1. Complete this form within 90 days.
- 2. Attach itemized bills
- 3. Mail to:

POMCO
PO Box 186
Syracuse, New York 13206
Phone: 866-834-4765

NOTICE TO CLAIMANTS:

The Intercollegiate Sports Insurance Plan has been designed to provide maximum benefits for minimum premium. Benefits will be paid for those eligible expenses not paid by your other insurance.

FLORIDA REQUIRED STATEMENT - ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NEW YORK REQUIRED STATEMENT - 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, 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.

PART 1A: POLICYHOLDER

Policyholder: _____ Policy No: _____

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Claimant's Name: _____ Social Security No. _____ Male or Female

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Date of Injury _____ Time _____

Where and how did injury occur? _____

At the time of injury, was the injured involved in any activity under the jurisdiction of the Policyholder? Yes No

Under whose supervision? _____ Was he/she a witness? _____

Sport participating in at time of injury _____

Date medical treatment first received _____

Signature: **X** _____ (Must be signed by an official of the Policyholder) Title _____ Date _____

PART 1B: STATEMENT OF THE INJURED PERSON

THIS PORTION OF THE STATEMENT MUST BE FILLED OUT COMPLETELY BEFORE CLAIM CAN BE PROCESSED.

Have you suffered same or similar condition in the past? Yes No If Yes, and you were treated, please give name & address of the physician who treated you: _____

_____ Dates treated: _____

Claimant's Employer _____ Business Phone No. () _____

Claimant's Employer's Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Spouse's Name _____ Social Security No. _____

Spouse's Employer _____ Business Phone No. () _____

Spouse's Employer's Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Parent's or Legal Guardian's Employer _____ Business Phone No. () _____

Parent's or Legal Guardian's Employer's Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

List ALL OTHER insurance policies. (If no other insurance policies, please indicate.) Group _____ Policy No. _____

Name of Other Insurer: _____ Individual _____ Policy No. _____

Other Insurer's Address _____ (STREET) _____ Other _____ Policy No. _____

_____ (CITY) _____ (STATE) _____ (ZIP) No Other Insurance

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED
EXPLANATION OF BENEFITS FROM OTHER INSURANCE MUST BE ATTACHED

