

**NATIONAL UNION FIRE  
INSURANCE COMPANY  
MAIL CLAIM FORM TO:  
MAKSIN MANAGEMENT CORP.  
P.O. BOX 2648  
CAMDEN, NJ 08101-2648  
(800) 257-6250**

## NOTIFICATION OF INJURY

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.

Policy Number
<b>FOR OFFICE USE</b>
Reference Number
Coverage Code

### FORM MUST BE COMPLETED IN FULL

<b>PART I – ACCIDENT REPORT</b>					
1A. Name of Organization			1B. Name of Team		
2A. Name of Claimant (Last)		(First)	(Middle Initial)	2B. Social Security No.	2C. Birthdate
2D. Sex					
3. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)					
4. Describe how accident occurred. (Please provide all details.) <b>MUST BE A BODILY INJURY DUE TO AN ACCIDENT.</b>					
5A. Did Accident Occur:		Yes	No	5B. a) Date of Accident	
a) while the claimant was supervised?		<input type="checkbox"/>	<input type="checkbox"/>	5C. Name of Activity	
b) during sponsored activity?		<input type="checkbox"/>	<input type="checkbox"/>		
c) during programmed hours?		<input type="checkbox"/>	<input type="checkbox"/>		
d) on activity premises?		<input type="checkbox"/>	<input type="checkbox"/>		
e) while traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group?		<input type="checkbox"/>	<input type="checkbox"/>		
		5D. (Check One)		5E. Name and Title of Supervisor	
		<input type="checkbox"/> Member/Player <input type="checkbox"/> Coach <input type="checkbox"/> Manager		_____	
6A. _____		6B. _____		6C. _____	
Signature of Coach, Manager or Delegated Authority		Title		Date	

<b>PART II – TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)</b>			
1A. Name of Father/Guardian or Claimant (if adult)	1B. Social Security No.	1C. Address/City/State/Zip	1D. Phone Number
2A. Name of Mother/Guardian or Spouse (if adult)	2B. Social Security No.	2C. Address/City/State/Zip	2D. Phone Number
3A. Name of Father/Guardian's or Claimant's (if adult) Employer	3B. Address/City/State/Zip of Employer		3C. Phone Number
4A. Name of Mother/Guardian's or Spouse's (if adult) Employer	4B. Address/City/State/Zip of Employer		4C. Phone Number
5A. Parent/Guardian's or Claimant's (if adult) Insurance Company(ies)	5B. Policy Number(s)	5C.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
6A. All other Insurance Company(ies) under which Claimant is insured	6B. Policy Number(s)	6C.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	

**Affidavit:** I verify that the above information regarding insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

\_\_\_\_\_  
Signature of Parent/Guardian or Claimant (if adult) Date

**Authorization:** I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

\_\_\_\_\_  
Signature of Insured (Parent or Guardian if claimant is under 18) Date

**SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM**