



1. PLEASE FULLY COMPLETE THIS FORM  
 2. ATTACH ITEMIZED BILLS  
 3. MAIL TO HSR  
 E-mail : [AXISclaims@hsri.com](mailto:AXISclaims@hsri.com)

Health Special Risk, Inc.  
 4100 Medical Parkway  
 Carrollton, Texas 75007  
 Phone: (866) 345-4299 Fax: (972) 512-5820

Policy Number: \_\_\_\_\_

Policy Name: \_\_\_\_\_

**PART I – POLICYHOLDER’S REPORT**

1. Claimant’s Name (Injured Person)		2. Social Security Number		3. Gender <input type="checkbox"/> M <input type="checkbox"/> F		4. Date of Birth		5. E-Mail	
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)									
7. If Applicable, Parent’s Name, Address, and Best Contact Phone Number (Include Area Code)									
8. Date and Time of Accident			9. Place where Accident Occurred			10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer			
Dental Claims	11. Indicate which Teeth were Involved in the Accident			12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial					
13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)						Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO			
14. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident									
15. Did Accident Occur (Check Yes or No for Each of the Following):									
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?						<input type="checkbox"/> YES <input type="checkbox"/> NO			
B. On activity premises?						<input type="checkbox"/> YES <input type="checkbox"/> NO			
C. While on the job (if applicable)?						<input type="checkbox"/> YES <input type="checkbox"/> NO			
D. While traveling directly and uninterruptedly to or from home and policyholder premises?						<input type="checkbox"/> YES <input type="checkbox"/> NO			
E. During intercollegiate/scholastic athletic practice?						<input type="checkbox"/> YES <input type="checkbox"/> NO or competition? <input type="checkbox"/> YES <input type="checkbox"/> NO			
16. Name of Event or Activity					17. Name and Title of Supervisor				
18. Name of Policyholder Representative					19. Title of Policyholder Representative			20. Date	

**PART II – OTHER INSURANCE STATEMENT**

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree?  
YES NO

If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_  
 Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_  
 Claimant’s primary employer name, address, and phone number \_\_\_\_\_

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	DATE
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**PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. **(if not signed, submit proof of payment)**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **Health Special Risk, Inc.** A photo static copy of this authorization shall be considered as effective and valid as the original.

I understand that 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.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.**

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## Important Fraud Notice

- ❖ ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** 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 Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ❖ ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ❖ ***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ❖ ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- ❖ ***For residents of Maine, Tennessee, Virginia and Washington:***  
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ❖ ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of New Mexico:*** 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 CIVIL FINES AND CRIMINAL PENALTIES.
- ❖ ***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.
- ❖ ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ❖ ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ❖ ***For residents of Pennsylvania:*** 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 subjects such person to criminal and civil penalties.