PLEASE PROVIDE ALL INFORMATION REQUESTED. INCOMPLETE SUBMISSIONS CANNOT BE PROCESSED.

ACCIDENT CLAIM FORM

SUPPLEMENTAL BENEFITS CLAIM
$2500 DEDUCTIBLE

AMEREVENT GROUP
535 C STREET
AMERICA'S CENTRAL PORT
GRANITE CITY, IL 62040
PHONE: (888) 254-6535
FAX: (888) 849-2882
EMAIL: INSURANCE@AMEREVENT.COM

SECTION I (please print)

Last Name of Claimant | First Name | Birth Date

Mailing Address

City | Province | Postal Code

If a Minor, Name of Parent

Home Phone ( ) | Business Phone ( )

SECTION II

Date of Accident | Hour a.m./p.m.

Location of Accident

What is the Injury?

Date of First Treatment

Name of Hospital taken to

Date of Admittance | Hour a.m./p.m.

Date of Discharge | Attending Physician or Dentist

SECTION III Describe fully how the accident happened.

SECTION IV (this accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses)

What medical coverage do you have through your/spouse/parent employment?

Name of Employer	Name of Insurer
Address of Employer	Address
City Prov. Postal Code	Policy No. Certificate

SECTION V

I hereby certify that all the information provided above is correct.

Claimant's / Guardian Signature | Date

Mail completed form along with any invoices for expensesyou had to pay yourself to: AMEREVENT GROUP, 535 C STREET, AMERICA'S CENTRAL PORT GRANITE CITY, IL 62040; or send by FAX: (888) 849-2882 or EMAIL: INSURANCE@AMEREVENT.COM. Please do not hesitate to email or call (P): 314-255-2882 if you have any questions regarding this form. Instructions are on the reverse side. If you do not have costs at this time, please forwardthe form only and confirm that you intend to make a claim.

CERTIFICATION OF EVENT HOST

Do not complete this section yourself; have the host organization of the event you attended complete this section.

Host Name: | Event Contract ID#:

Address, City, St, Zip:

Was the person above authoirzed to use equipment at the time of injury? Yes/No

Is the signed waiver required for participation on hand? Yes/No

Name | Position with Host

Telephone No. | Signature

INSTRUCTIONS

You must provide all information requested; incomplete claim forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Intial notice of your accident must be received within 30 days of the accident date, and claim documentation must be received within 90 days.

2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
   patient's name
   type of purchase or service
   date of each purchase or service
   amount charged for each purchase or service

3. A physician statement confirming diagnosis and recommended treatments is required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible, specified in your plan details, will be considered for payment up to your maximum benefits.

5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.

• IF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:
(Please check your plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

• FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

A. PRESCRIBED DRUGS
   -name of medication or drug
   -date of purchase
   -amount charged

B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
   -physician referral
   -type of service
   -date of each treatment
   -amount charged for each treatment
   -dates of treatments paid by any Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION
   -not an eligible expense

D. AMBULANCE (Emergency to Hospital only)
   -date of service
   -places ambulance taken from and to
   -amount charged

E. VISION CARE
   -if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
   -an explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY
   -if your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable.
   -a statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES
   -a letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed, must be submitted with your receipt
   -medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS
   -exact date of accident
   -breakdown of services performed
   -circumstances surrounding the accident
   -is there other dental coverage? Enclose details
   -confirmation that treatments only relate to the accident
   -provide other insurer's explanation
   -are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
   -this Accident Policy does not make payment for any service or treatment that is available from another source of payment or at a reduced cost except as such savings are included and deducted herein.

NOTE; THIS ACCIDENT POLICY INCLUDES A $2,500 DEDUCTIBLE THAT MUST BE PAID (NOT AEG) AND YOUR PERSONAL HEALTH INSURANCE, HEALTH PLANS, LIABILITY INSURANCES AND DISCOUNTS MUST BE USED FIRST. YOU MUST PROVIDE DOCUMENTATION OF THIS.

AMEREVENT GROUP
535 C STREET
AMERICA'S CENTRAL PORT
GRANITE CITY, IL 62040

PHONE: (888) 254-6535
FAX: (888) 849-2882EMAIL:
INSURANCE@AMEREVENT.COM

PART 1 DENTIST

Dentist's Name

Address

City, Province

Postal Code

Telephone

Patient's Last Name | Given Names

Address | Apt.

City, Province

Postal Code

Date of Service Day	Mo	Yr	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charged. E. & OE.

Total Submitted Fee

Dentist's Signature

Date: Day Month Year

FOR DENTIST'S USE ONLY.
For additional information Re: diagnosis, procedures, or complications, and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

Signature of Patient (or Parent/Guardian)

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Signature of Subscriber

FOR PLAN ADMINISTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note - Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your co-operation will be appreciated.

CLAIM APPROVED:

Day Month Year Assessor

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated – use procedure code if possible	Est. Date -Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame.

Date Day Month Year

Dentist's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

_____

_____

_____

_____

_____

_____

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Discharged: _____

If referred to you, give name of referring physician:

_____

Operations (or other procedures performed):

_____ Date: _____

_____ Date: _____

_____ Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ Date of Accident: _____

Has the patient ever had same or similar condition? _____

If "Yes", please state when and describe: _____

_____

Is there any other disease or infirmity affecting the present condition?

_____

Date: _____ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____

SUPPLEMENTAL BENEFITS CLAIM

FORM-SBCCOSTS

COSTS SUMMARY

PLEASE PROVIDE SUPPORTING INVOICES OR RECEIPT FOR EACH EXPENSE CLAIMED

	VENDOR	BILL #	BILL ($) TOTAL	ALL DISCOUNTS & ADJUSTMENTS ($) AVAILABLE	$ AMT TO BE PAID BY INSURANCE OR OTHERS	$ AMOUNT REMAINING	$ PORTION OF REMAINDER ALREADY PAID BY CLAIMANT
1			$	$	$	$	$
2			$	$	$	$	$
3			$	$	$	$	$
4			$	$	$	$	$
5			$	$	$	$	$
6			$	$	$	$	$
7			$	$	$	$	$
8			$	$	$	$	$
9			$	$	$	$	$
10			$	$	$	$	$

HEALTH INSURANCE, MEDICAL PLANS, DISCOUNTS AND OTHER ADJUSTMENTS AVAILABLE TO CLAIMANT (PHOTOCOPIES OF INSURANCE CARDS MAY BE SUBMITTED).

	NAME OF INSURANCE, PLAN, DISCOUNT OR OTHER	POLICY #, PLAN# OR OTHER IDENTIFYING #.	CONTACT PHONE
1			
2			
3			
4			
5			

I affirm I have disclosed all payments, adjustments, discounts and reimbursements made or expected from all sources so that supplemental coverages can be accurately determined. I agree once a determination is made based upon my submission above, no further claims shall be valid.

Signature of Claimant (over age 18)

Date

Printed Name of Claimant

AFFIDAVIT

The undersigned, swears, affirms or, deposes the truth and accuracy of the following under penalties of perjury that:

1. The attached accident report I have submitted under my name is true and accurate.
2. At the time of said accident, I understood and agreed to the terms, risks and conditions of use and was fully capable and authorized to use all equipment involved.
3. I had not consumed intoxicating substances within 1 hour of the time of said accident.
4. I understand and agree: (4-1) that as a condition of use all coverages available from the EVENT ORGANIZERS (as defined in the event order contract) are supplemental and for incurred medical costs only after my own medical insurance, plans and discounts have been fully used; (4-2) that I will disclose and demonstrate all payments made; (4-3) that no economic recovery (lost wages, lost benefits, lost activities, etc), future damages or other costs or losses can be considered or are reimburseable; and (4-4) that the limit of coverages is $5,000 with the first $2500 of coverable costs payable by the EVENT HOLDER (equipment renter).
5. I affirm I have disclosed all medical insurance, plans and discounts, including provider name, address, phone number and policy number, all insurance cards and all payments and reimbursements made or expected so that supplemental coverages can be accurately determined. I agree once a determination is made based upon my submissions no further claim shall be valid.

_____ _____

Signature of Claimant (over age 18) Date

_____

Printed Name of Claimant

CERTIFICATION

The above named claimant, _____ , appeared before me and subscribed, and swore or affirmed that the foregoing Affidavit is true, correct and executed as a knowing, free and voluntary act for the purposes stated this ____ day of _____ 20___.

_____ (SEAL)

Notary Public