Office of Youth Ministry/CYO
Archdiocese of San Antonio
2718 W. Woodlawn Ave
San Antonio, Texas 78228
(210) 734-2620 ext. 1116

Accident Report Form To Be Completed

CYO Registration Year **2009-2010** Registration Number

Full Name Address (Street, City, State, Zip)

Date of Birth Telephone Parish

Item 1:
Date of Injury Sport/Position Location (Gym, Field, Etc.)

Give full description of injury from which you are suffering, tell **Where, When, And How** it happened.
Full Details Please

Hospital Address

Dates of Confinement From To

Do you have insurance, including Student Accident Insurance? ☐ Yes or ☐ No
If yes, which insurance carrier?

To Be Completed By Club Official

Item 2:
I hereby certify that the above is a member of our parish CYO Program for the 2009-2010 year and that the above injury was sustained while participating in official CYO activities under adequate organizational supervision.

Name of Parish and Zone ______________________
Name of Division ______________________
Injury Occurred during ________ Practice________ Game________ Other________
Coaches Signature ______________ Date________ Telephone________
Address ______________________
Parish Presidents' Signature______________ Date________

ALL REQUEST MUST BE SUBMITTED WITHIN 14 DAY OF INJURY

Note: All Signatures Must Be Obtained Before Request Is Submitted To CYO Office

CLAIM INSTRUCTIONS

Treatment must commence within 90 days from the date of the accident.

1. In case of an accident, notify the school/organization immediately.

2. Notify **ALL** treatment facilities (physician's office, hospital, etc.) of this insurance coverage so that any invoices and/or Explanation of Benefits (EOB) can be sent directly from the medical facility to The Maksin Group.

3. Have Part I and Part II completed on the Notification of Injury form. Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

4. Attach any itemized bills to the claim form, along with any corresponding Explanation of Benefits (EOB) for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax i.d. number. Balance Due bills are not acceptable. Be sure to attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service. Please Note: Both an itemized bill and EOB (if applicable) must be submitted for claims to be considered for accident medical expense benefits.

5. Mail the Notification of Injury form, along with any other applicable correspondence to our office within 90 days from the date of the accident. Do not leave this form with the school, coach, hospital, physician, etc. Our address is **Maksin Management Corp., P.O. Box 2648, Camden, NJ 08101-2648.** If you need further assistance, feel free to contact Customer Service at **1-800-257-6250**. We will be happy to assist you.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.

NOTIFICATION OF INJURY

Policy Number

MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP.
P.O. BOX 2648
CAMDEN, NJ 08101-2648
(800) 257-6250

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 OFFICE USE

Reference Number
Coverage Code

FORM MUST BE COMPLETED IN FULL

PART I – ACCIDENT REPORT

1A. Name of School

1B. Name of School District/Diocese/Association

2A. Name of Student (Last) (First) (Middle Initial)

2B. Social Security No.

2C. Grade

2D. Birthdate

2E. 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.) **MUST BE A BODILY INJURY DUE TO AN ACCIDENT.**

5A. Was the accident school-related? ❑ Yes ❑ No

5B. Is the accident covered under a catastrophic policy? ❑ Yes ❑ No

6A. Did Accident Occur:	Yes	No
a) while the claimant was supervised?	❑	❑
b) during sponsored activity?	❑	❑
c) during programmed hours?	❑	❑
d) on activity premises?	❑	❑
e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities?	❑	❑

6B. a) Date of Accident

b) Time

c) Place

6C. Name of Activity

6D. Name and Title of Supervisor

7A. ______________________ Signature of School Officer

7B. ______________________ Title

7C. ______________________ Date

PART II – TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)

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.
______________________	______________________	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
______________________	______________________	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
______________________	______________________	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.

6A. All other Insurance Company(ies) under which Claimant is insured	6B. Policy Number(s)	6C.
______________________	______________________	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
______________________	______________________	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
______________________	______________________	❑ Medicaid ❑ Individual ❑ Group ❑ 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

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