

# Participant Accident Claim Form

**CIGNA Group Insurance**  
Life Insurance Company of North America **CIGNA**



Any person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person, files a claim or application containing materially false, incomplete, or misleading information or conceals information concerning any material fact thereto, commits and is guilty of a fraudulent insurance act which may constitute a felony under state law and may subject the person to criminal and civil penalties.

## INSTRUCTIONS FOR FILING A CLAIM

### THIS FORM IS FOR MEDICAL BENEFITS ONLY.

YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

- To the Claimant:
- A. Complete the Claimant Section on the bottom of this form (Part B).
  - B. Return the completed form to your Group Official who will submit the form to MIC.
- To the Group Official:
- A. Give the form to the Claimant for completion of the Claimant Section.
  - B. Complete the Group Official's Section (Part A).

Submit completed form to: **MIC, 552 S. WASHINGTON, SUITE 111, NAPERVILLE, IL 60540** **ATTN:CLAIMS**

### PART A TO BE COMPLETED BY GROUP OFFICIAL

NAME OF POLICYHOLDER AND POLICY NUMBER

Ohio Hot Stove Baseball League, Inc., SPS922750-1010

02/13/2001 to 02/13/2002

NAME OF CLAIMANT

OCCUPATION (IF APPLICABLE)

DATE OF BIRTH

SEX

M  F

ADDRESS OF CLAIMANT

(STREET)

(CITY)

(STATE)

(ZIP CODE)

CLAIMANT'S SOCIAL SECURITY NO.

NAME OF LEAGUE, TEAM, OR ORGANIZATION (IF DIFFERENT THAN GROUP POLICYHOLDER)

ADDRESS OF LEAGUE, TEAM, OR ORGANIZATION (STREET)

(CITY)

(STATE)

(ZIP CODE)

DATE AND TIME OF ACCIDENT

A.M.  
 P.M.

PLACE OF ACCIDENT

NATURE OF INJURY

WHAT CAUSED THE ACCIDENT?

DESCRIBE TYPE OF SPORT OR ACTIVITY ENGAGED IN AT TIME OF ACCIDENT

NAME OF SUPERVISOR OF THE ACTIVITY

WITNESS TO ACCIDENT (NAME AND ADDRESS)

### SIGNATURE OF GROUP OFFICIAL

I believe the above information is correct.

Signature of Official

Title

Date Signed

### PART B TO BE COMPLETED BY CLAIMANT/PARENT

Is claimant covered under any other health/accident insurance prepayment plan?  Yes  No

If yes, please list names and address and identifying information, i.e. policy and Social Security number.

If available, please submit a copy of an Explanation of Benefits from your other insurance carrier or prepayment plan.

### AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information to Life Insurance Company of North America, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

Name of Claimant

Signature of Claimant (Parent or Guardian in the event of minority or incapacity)

Date Signed

### PAYMENT AUTHORIZATION

I authorize payment directly to those physicians or providers as indicated on the enclosed bills, of medical benefits otherwise payable to me.

Signature of Claimant (Parent or Guardian in the event of minority or incapacity)

Date Signed

MIC897 The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.