PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039
specialriskCS@wellfleetinsurance.com
fax: (413) 733-4612

PLEASE FULLY COMPLETE THIS FORM

ATTACH ITEMIZED BILLS

MAIL ALL INFORMATION TO THE ABOVE ADDRESS

PART I – POLICYHOLDER'S REPORT

Participating Group Number:	Policyholder Number:	Policyholder Name:	Event, Activity or Sport
SR510935K2	MP0000868116	Roman Catholic Diocese of Syracuse	

Claimant's Name (Injured Person)	Social Security Number	Gender	Date of Birth	E-Mail Address
		☐ M ☐ F		

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a:
		☐ Particpant ☐ Staff Member ☐ Other

Dental Claim	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident:
		☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured and left or right side– e.g. broken arm, sprained ankle, etc.)

Did Injury Result in Death? ☐ Yes ☐ No

Describe How Accident Occurred – Give All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?	☐ Yes	☐ No
B. On activity premises?	☐ Yes	☐ No
C. While traveling directly and uninterruptedly to or from the event?	☐ Yes	☐ No
D. During intercollegiate/scholastic athletic practice or competition?	☐ Yes	☐ No

I certify that the above information is correct to the best of my knowledge and belief, that the person named above is insured by the policy, and that his or her insurance was in effect on the date the accident occurred.

Signature of Plan Sponsor	Name, Title and Telephone Number of Plan Sponsor	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you 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 an employer, a parent's employer or other source?

☐ Yes ☐ No

If yes name of insurance company: _____ Policy #: _____

Other Insurance Carrier ID# _____ Other Insurance Carrier Telephone# _____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐ Yes ☐ No If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

I agree that should it be determined at a later date there is another insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

SIGNATURE _____ DATE _____

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, please provide 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 Wellfleet Group, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

I certify that the above information is correct to the best of my knowledge and belief. I understand that any person who knowingly and with the intent to defraud or deceive any
insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ DATE _____

FRAUD STATEMENTS

Important Notice

- *In General, and specifically for residents of Arkansas, 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 and 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 and 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.