

IMPORTANT NOTICE:

This insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.



- 1. PLEASE FULLY COMPLETE THIS FORM
 - 2. ATTACH ITEMIZED BILLS
 - 3. MAIL OR EMAIL TO HSR
- E-mail : claims@hsri.com

HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 Phone: (972) 512-5600 Fax: (972) 512-5820
 Toll Free (800) 328-1114

Policy Name: _____

Policy Number: _____

PART I - POLICYHOLDER & INSURED

1. Promoter/Team/League Name		2. Policy Number/Class Code	
3. Claimant - Last Name, First Name		4. Claimant Social Security Number	
5. Mailing Address where Insurance Info/Requests should be mailed		6. City, State, Zip	
7. Birthdate	8. Male <input type="checkbox"/> Female <input type="checkbox"/>	9. Phone	10. Email
INJURY - Please Complete this Section to report an Injury			
11. Date of Injury	12. Time & Address where occurred?	13. Part of body injured	
14. How did injury occur (description of incident)?			15. Date of first medical treatment
16. Type of Sport (if applicable):		17. Sport Designation: <input type="checkbox"/> Practice <input type="checkbox"/> Game <input type="checkbox"/> Event <input type="checkbox"/> Other	
18. Action Taken: <input type="checkbox"/> Released to Parent <input type="checkbox"/> Ambulance Transport <input type="checkbox"/> Referred to Hospital/Clinic <input type="checkbox"/> Own Accord (Adult) <input type="checkbox"/> Other _____			
19. Claimant Designation: <input type="checkbox"/> Coach/Manager <input type="checkbox"/> Volunteer <input type="checkbox"/> Participant <input type="checkbox"/> Umpire/Referee <input type="checkbox"/> Other			
20. Was the claimant supervised when injured? Yes <input type="checkbox"/> No <input type="checkbox"/>		21. Was injury during travel to or from scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. Signature of Policyholder: _____		Date _____	

PART II – PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)

1. Father/Guardian Name		9. Mother/Guardian Name	
2. Home Address (Street, City, State, Zip)		10. Home Address (Street, City, State, Zip)	
3. Telephone	4. Email	11. Telephone	12. Email
5. Employer		13. Employer	
6. Father's Employer Address (Street, City, State, Zip)		14. Mother's Employer Address (Street, City, State, Zip)	
7. Business Phone		15. Business Phone	
8. Employer Medical Insurance Policy (8a) Policy Number: _____ (8b) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/> (8c) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>		16. Employer Medical Insurance Policy Address: _____	

PART III – INSURANCE VERIFICATION

Is Claimant covered by any other insurance policy (other than this policy), either as a dependent, group, individual, automobile medical or liability? Yes No

If yes, Policy Number: _____ Name of Insurance Carrier: _____

Address of Insurance Carrier: _____

Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.

I hereby authorize any hospital, policyholder, physician, employer, or other person who has attended or examined the Claimant to disclose when requested to do so, any information to HSR CLAIMS or POLICYHOLDER with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A copy of this authorization shall be considered as valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to

X _____
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

X _____

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.

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