



USA DIVING ACCIDENT CLAIM FORM



COMPLETE THIS FORM. ATTACH ALL BILLS AND PRIMARY EXPLANATION OF BENEFITS.

MAIL TO: A-G Administrators, LLC: PO Box 21013, Eagan, MN 55121

SUBMIT ELECTRONICALLY: usadiving@usadiving.org

For questions, please call: 610.933.0800 or email customerservice@agadm.com

- Participant (or legal guardian if under the age of 18) must complete this form in its entirety or it may be returned to you by the USA Diving State Association/Nationwide affiliate.
- Do not delay submitting this claim form.** This form must be received, with or without attachments, within 90 days from the date of the accident, or benefits may be denied due to untimely filing. It must be completed in its entirety. Answer every section.
- Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your USA Diving State Association/Nationwide affiliate office for validating.

IF PARTS A and B ARE NOT COMPLETED IN FULL, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED. Please print or type.

PART A - This section MUST be completed, dated and signed by the Injured Person - or by his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.

1. Name of Injured Person (Insured): <i>First /Middle/Last</i>	1a. Date of Accident: <i>Mo/Day/Year</i>	
2. Complete Mailing Address: <i>Street/City/State/Zip</i>		
3. Area Code/Home Ph#:	3a. Area Code/Cell Phone#:	3b. Email Address:
4. Is the injured person a Medicare/Medicaid beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No		4a. If Yes, please provide Social Security number or Health I.D. number: _____
5. Date of Birth: <i>Mo/Day/Year</i>		
6. <input type="checkbox"/> Male <input type="checkbox"/> Female	6a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Full-time Student	
7. Are you currently enrolled in any health insurance and/or other accident plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.		
Company Name: _____	Group Name: _____	Policy Number: _____
Company Name: _____	Group Name: _____	Policy Number: _____
7a. If you are not enrolled in any health insurance plan, we require written verification from your employer and your spouse's employer (if applicable), or Bursar's office if you are a full-time college student.		
7b. If you are self- employed or unemployed and not covered under any health insurance plan, please sign below.		
Signature of Diver: _____		



PART B - This section MUST be completed in full, then signed by an official of your local organization.

1. Team name: _____ 1a. League name: _____

2. State Association/Nationwide affiliate: _____ 2a. Region: _____

3. Injury occurred at: Game Practice Travel Other Event

4. Event: _____ 4a. Injury occurred on: _____
___ 1 Meter springboard ___ Practice, dry land training/strength & conditioning
___ 3 Meter springboard ___ Practice, diving
___ 3 Meter platform ___ Competition
___ 10 Meter platform

5. Describe how accident occurred:

6. Type of injury (example: broken arm, sprained ankle, broken nose, etc.):

6a. Body part injured (example: ankle, knee, shoulder, head, etc.):

7. Name and Phone Number of coach, manager or referee present at the time of the accident:

8. *I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include prosecution.*

Signature of USA Diving Authorized Official: _____ Title: _____



AUTHORIZATION



I waive any provision of law to the contrary and hereby authorize any hospital, physician or other person who has attended me and my insurance carrier or employer to furnish to A-G Administrators or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, and copies of all hospital, medical or insurance records including, but not limited to, information regarding other insurance coverages. I agree that a photocopy of this authorization shall be considered as effective as the original.

Notice to CALIFORNIA RESIDENTS: The California Consumer Privacy Act (CCPA) is a comprehensive privacy law that went into effect on January 1, 2020. The CCPA provides enhanced rights to California residents, including a right to access information, a right to delete information (in certain circumstances), and a right to opt out of the sale of information. Please direct any inquiries regarding the CCPA to your third party administrator claim representative.

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

WARNING TO THE RESIDENTS OF:

Alabama: presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or specific to AR and RI: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky: and with intent to defraud any insurance company or other person files a 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.

New York: 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.

Pennsylvania: 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.

Louisiana: 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.

New Mexico: 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.

Texas: presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

West Virginia: 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.

Maryland: 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.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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.

Oklahoma: 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.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include prosecution.

Signature of Diver: _____

Date: _____



To expedite proper processing, submit this completed form along with all requested documents to the following address: A-G Administrators, LLC; PO Box 21013, Eagan, MN 55121
Electronically: usadiving@usadiving.org
AFTER you receive your acknowledgment letter, you may contact A-G Administrators at 610.933.0800

