

**MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP.
CN 98000
PENNSAUKEN, NJ 08110
(800) 257-6250**

NOTIFICATION OF INJURY

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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

Policy Number

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? <input type="checkbox"/> Yes <input type="checkbox"/> No			5B. Is the accident covered under a catastrophic policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6A. Did Accident Occur:		Yes	No	6B. a) Date of Accident	6C. Name of Activity
a) while the claimant was supervised?		<input type="checkbox"/>	<input type="checkbox"/>		
b) during sponsored activity?		<input type="checkbox"/>	<input type="checkbox"/>	b) Time	
c) during programmed hours?		<input type="checkbox"/>	<input type="checkbox"/>		
d) on activity premises?		<input type="checkbox"/>	<input type="checkbox"/>		
e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities?		<input type="checkbox"/>	<input type="checkbox"/>	c) Place	6D. Name and Title of Supervisor
7A. _____		7B. _____		7C. _____	
Signature of School Officer		Title		Date	

PART II – TO BE COMPLETED BY PARENT OR GUARDIAN			
1A. Name of Father or Guardian	1B. Social Security No.	1C. Address/City/State/Zip of Father or Guardian	1D. Phone Number
2A. Name of Mother or Guardian	2B. Social Security No.	2C. Address/City/State/Zip of Mother or Guardian	2D. Phone Number
3A. Name of Father or Guardian's Employer		3B. Address/City/State/Zip of Employer	3C. Phone Number
4A. Name of Mother or Guardian's Employer		4B. Address/City/State/Zip of Employer	4C. Phone Number
5A. Father or Guardian's Insurance Company(ies) _____	5B. Policy Number(s) _____	5C. <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Government <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Government	
6A. Mother or Guardian's Insurance Company(ies) _____	6B. Policy Number(s) _____	6C. <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Government <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Government	
7A. All other Insurance Company(ies) under which the claimant is insured _____	7B. Policy Number(s) _____	7C. <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Government <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Government	

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 or Guardian

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

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, CN 98000, Pennsauken, NJ 08110**. 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.