CLAIM INCIDENT REPORT FORM
RHA Inc. dba Roller Hockey Alliance A-SP-SU-23-09-06-286071

Please fill out Claim / Incident Report Form where applicable.

To prevent delays, please provide documentation from the Claimant's health-care provider, if available, to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits. Please be advised that failure to complete all sections may result in delay in processing this claim. Be advised it may become necessary to request additional materials and/or interview witnesses in order to make a coverage determination. Disclaimer: Some of the services listed may not be covered by the policy.

NAMED INSURED: RHA Inc. dba Roller Hockey Alliance EVENT ACTIVITY OR SPORT: Roller Hockey

Select each of the following that applies – Did the accident occur

☐ During a participating organization sponsored & supervised or sanctioned activity
☐ on activity premises
☐ During a participating organization practice

Name & Title of Representative Submitting the Claim Contact email address Contact Telephone #

Name of RHA representative signing the form Contact email address Contact Telephone #

Will the RHA representative signing the form be the primary point of contact for claims queries other than those handled between the insurer and the claimant ☐

CLAIMANT INFORMATION

First Name Last Name Middle Name Date of Birth Gender

Telephone # Email

Guardian or Accompanying Adult Name Guardian or Accompanying Adult Telephone #

Home Address Number & Street City State Zip

Please describe incident / injury

ACCIDENT INJURY DETAILS

Accident Location Was another guest / participant injured? Yes ☐ No ☐ Was EMS called? Yes ☐ No ☐

Was law enforcement called? Yes ☐ No ☐ Was a weapon involved Yes ☐ No ☐

Day of week of incident Date of incident Time of incident AM ☐ PM ☐

Incident / Injury Business Hours Event? After hours Yes ☐ No ☐

Type of incident Type of Injury Body Part Injured

Injury Attraction or General Arena Incident Location Attraction

Were rule signs visible at attraction of incident/injury	Yes ☐ No ☐	Guest requested contact for claims	Yes ☐ No ☐
Were general court rules / signs visible at waiver station	Yes ☐ No ☐	Waiver for guest / participant	Yes ☐ No ☐
Guest requested financial assistance with medical bill	Yes ☐ No ☐	Waiver kiosk operational	Yes ☐ No ☐
Injury/Incident is mentioned on Social Media or by Reporter	Yes ☐ No ☐	Electronic or Paper Waiver	
Video footage available of incident / injury	Yes ☐ No ☐	Accident location operational	Yes ☐ No ☐
Has insured made contact with the guest post incident	Yes ☐ No ☐	Waiver saved	Yes ☐ No ☐
Has the incident / injury class been updated (if applicable)	Yes ☐ No ☐	Video(s) saved	Yes ☐ No ☐

Was the patient confined to the hospital as a result of this injury? Yes ☐ No ☐
(If yes, please submit the itemized hospital bills along with a personal medical insurer statement of benefits in response to these bill(s))

Hospital Name Hospital Address

Was the patient transported by an ambulance as a result of this injury? Yes ☐ No ☐
(If yes, please submit the itemized ambulance bill along with a personal medical insurer statement of benefits in response to this bill)

Was an aid in locomotion (mobility) prescribed as a result of this injury? Yes ☐ No ☐
(crutches, wheelchairs, leg braces, walkers, cervical collars)

If any of the following were the result of your injury, please provide medical reports, physician's office notes, or any bills received for these conditions that describe the diagnoses or type of treatment received.

☐ Coma ☐ Burn ☐ Laceration ☐ Dislocation ☐ Injury to eye ☐ Paralysis

☐ Concussion (major diagnostic exam reports are acceptable) ☐ Fractures (x-ray reports or major diagnostic exam reports are acceptable)

Was surgery performed as a result of this injury? Yes ☐ No ☐
(If yes, please submit a copy of the operative report or detailed billing from the surgeon's office along with a personal medical insurer statement of benefits in response to these bill(s))

Was a major diagnostic exam (CT scan MRI, MRA, EEG) performed as a result of this condition? Yes ☐ No ☐
(If yes, please submit a copy of the exam report and billing information along with a personal medical insurer statement of benefits in response to these bill(s))

Details of Therapy of Treatment: Date of Treatment Type of Treatment ☐ Therapy ☐ Follow-up

Provider Name Address Phone Number

Some policies provide benefits for therapy including physical speech and occupational therapy. Not all types are available on all policies. Please submit information indicating the date of treatment, treatment type and who provided it to determine the benefit.

OTHER INSURANCE DETAILS

Do you have other insurance Yes ☐ No ☐
Is the other insurance one of the following types of coverage ☐ Group (Employer ☐ Individual ☐ Government ☐ Medicaid

List Name, Address & Phone # of other insurance companies under which claimant is insured

Policy # or Account #

If claimant is a minor, name of claimant's guardian(s) and relationship to claimant

Guardian Social Security #(s)

Name / Address / Telephone number of employer (if claimant is a minor, guardian's employer)

Employers Daytime Tel #

AUTHORIZATIONS

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 **Co-ordinated Benefit Plans, on behalf of the Axis Insurance Company** or its designated administrator. This authorization shall remain valid for a period of two years from the date signed. A photo static copy of this authorization shall be considered as effective and valid as the original. A copy of the authorization is available upon request of the company.

I agree that should it be determined, at a later date, there is other insurance (or similar), to reimburse **Co-ordinated Benefit Plans, on behalf of the Axis Insurance Company** to the extent of any amount collectible. 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

Name of person completing the incident form Title of person completing the incident form

Signature of RHA representative

Important Notice

• **In General, and specifically for residents of Arkansas, Illinois, 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 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 or 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 or 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.

• **For residents of Texas:** Any person who knowingly 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.

• **For resident of Virginia:** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.