



AG ADMINISTRATORS  
SPORTS INSURANCE SPECIALISTS



All bills must be submitted to any Group, Hospital, and/or Medical Plan to which the claimant may be eligible. The primary insurer's Explanation of Benefits indicating payments and/or denials must accompany this claim form.

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Please return this completed claim form to:

A-G Administrators LLC PO Box 21013 Eagan, MN 55121 www.agadministrators.com

Phone: 610.933.0800 Fax: 610.933.4122 Email: claims@agadm.com

Complete in detail to insure prompt handling A-G PAYOR ID# 11370

Any person who knowingly presents a false or fraudulent claim for payment of 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.

PART I

Name of College or University, City and State <b>Los Angeles Community College District</b>	Policy Number <b>EHH000100</b>
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Select location:

- ( ) City College 1000001      ( ) East L.A. College 1000002      ( ) Harbor College 1000003
- ( ) Mission College 1000004      ( ) Pierce College 1000005      ( ) Southwest College 1000006
- ( ) Trade-Tech College 1000007      ( ) Valley College 1000008      ( ) West L.A. College 1000009

Claimant's Full Name      Street Address      City      State      Zip + 4

Date of Birth      Social Security # or Student I.D. #      Phone #      Email Address

Parent or Guardian's Full Name      Street Address      City      State      Zip + 4

Phone #      Email Address

1. Give full description of injury:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Give exact date and time when injury occurred. Date: \_\_\_\_\_ Time: \_\_\_\_\_ am ( ) pm ( )

3. Date when claimant first consulted a physician for this condition? \_\_\_\_\_

4. Has the claimant been previously troubled with this condition? Yes ( ) No ( ) Date: \_\_\_\_\_

Location where treatment was received: \_\_\_\_\_

**A-G Administrators LLC does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.**

**PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT THE TIME OF SUBMISSION.**

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to A-G Administrators LLC, the underwriting company, and supervising official. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

If Authorized Representative, Relationship to Patient \_\_\_\_\_

or Legal Designation \_\_\_\_\_

STREET      CITY      STATE      ZIP CODE + 4

Please Print All Information

PART II

Did accident occur (check yes or no) Y N
(a) While claimant was supervised? ( ) ( )
(b) During sponsored activity? ( ) ( )
(c) During programmed hours? ( ) ( )
(d) On college premises? ( ) ( )
(e) While traveling to or from a regularly scheduled activity in a supervised group? ( ) ( )
(f) Accident/Non-Sport? ( ) ( )
(g) Intercollegiate Sport? ( ) ( )
(g1) Competition? ( ) ( )
(g2) Practice? ( ) ( )

Type of sport or activity: \_\_\_\_\_

Name and Title of Supervising College Official

Name: \_\_\_\_\_ Title: \_\_\_\_\_

I hereby certify that the statements made are correct to the best of my knowledge and belief, that the above-named claimant was insured hereunder at the time of the accident, and that the above injury was sustained while participating in official activities under adequate organizational supervision on:

\_\_\_\_\_, 20\_\_\_\_\_, Date of Injury

Signature of College Official: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

PART III

Nature of injury/Diagnosis: \_\_\_\_\_

ICD10 Codes: \_\_\_\_\_

Part of body:

( )Head ( )Neck ( )Arm ( )Wrist ( )Elbow
( )Hand ( )Leg ( )Knee ( )Ankle
( )Other: \_\_\_\_\_

Sport or Activity: \_\_\_\_\_

Athlete's position: \_\_\_\_\_

Gender ( )Male ( )Female

Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Time classes commence on date of injury:

\_\_\_\_\_ am \_\_\_\_\_ pm

Date of Injury: \_\_\_\_\_

Where did injury occur:

( )Game ( )Practice ( )Drills ( )Weight room / training
( )School time ( )Playground ( )Gym / PE Class ( )Field Trip
( )Other: \_\_\_\_\_

Playing Surface:

( )Grass ( )Turf ( )Hardwood
( )Other: \_\_\_\_\_

Season or Pre-Season:

( )Season ( )Pre-Season

Medical treatment available / provided: \_\_\_\_\_

Claims and payments by provider: \_\_\_\_\_

PART IV

Is claimant currently covered by any other insurance plan? ( ) Yes ( ) No

Is claimant currently covered by MediCal, Medicaid, Medicare, Tricare or any other Government Insurance? ( ) Yes ( ) No Name of Insurance

Company: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of person carrying other insurance coverage: \_\_\_\_\_

*The laws of some states require us to furnish you with the following notices:*

**WARNING. Any person who knowingly:**

**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.