QBE Insurance Corporation

Accident Claim Form

Mail to

NAHGA Claim Services
POBox189
Bridgton, ME 04009
E-mail: claims@nahga.com
Fax: (207) 647-4569
Questions? Contact (800) 952-4320

MAGNACARE℠ First Health.

In NY, network access provided by MagnaCare. Outside the MagnaCare network, access will be provided by First Health.

Caution

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. **Residents of the following states, please see last page: CA, CO; DC, FL, NY, TN, TX and VA.**

Instructions

- **Part I** - Must be completed by Policyholder.
- **Part II** - Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor.
- All fields must be completed.
- Send copies of itemized bills showing provider's name, address, Tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier. This does not apply if the accident policy provides primary coverage.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.
- For additional instructions about how to file a claim please visit www.ajfusa.com/claims

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

Part I – Policyholder Report

Name of Policyholder: TOWNSHIP OF MAHWAH

Policy number: KHH000097

Policyholder address: 475 CORPORTE DRIVE

City: MAHWAH

State: NEW JERSEY

Zip code: 07430

Policyholder contact: Dennis J. Burns

Email: rdirector@mahwahtwp.org

Fax:

Phone: 201-529-5757 x 254

Last name of Claimant

First name of Claimant

Social Security number

Date of birth

Sex: ☐ Male ☐ Female

Grade (if applicable)

Check one (if applicable): ☐ Day School ☐ Boarding School

Nature of injury (Describe, fully indicate what part of body was injured – e.g. broken arm, sprained ankle)
Must be a bodily injury due to accident

Describe how the accident occurred, provide all details. Attach a separate sheet, if necessary **(include name of Sport/Activity).**

Did accident occur:

During a Policyholder supervised/authorized activity?	☐ Yes	☐ No
During a Policyholder sponsored activity?	☐ Yes	☐ No
During scheduled Policyholder hours?	☐ Yes	☐ No
While traveling to or from a Policyholder sponsored and supervised activity?	☐ Yes	☐ No
Off Policyholder premises, at home, during the weekend, holiday or summer vacation?	☐ Yes	☐ No

Date of accident

Time of accident ☐AM ☐PM

Place of accident

First treatment date

Name and title of person supervising activity?

Was he or she a witness? ☐ Yes ☐ No

List other Policyholder insurance. Attach separate sheet, if necessary.

Policy number(s)

Signature of authorized Policyholder representative

Title

Date

X

Part II – To be completed by Claimant or Parent / Guardian, if Claimant is a minor

Name of Claimant or Father/Guardian | Social Security number | E-mail address

Name of Mother or Guardian | Social Security number | E-mail address

Street address of Parents or Claimant Guardian | City | State | Zip code

Telephone number | Father or Guardian's insurance company | Mother or Guardian's insurance company

Name and address of Claimant or Father/Guardian's employer, if a minor. | City | State | Zip code

Name and address of Claimant or Mother/Guardian's employer, if a minor. | City | State | Zip code

List all other insurance policies under which Claimant is insured | Policy number

Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (front and back).

Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of PPO or organization

Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of HMO or organization

If Claimant has health care coverage as a dependent from a previous marriage as mandated in a diverce decree, please provide the following:

Name of Policyholder | Name of insurance company | Policy number

Affidavit

I verify that the statement on other 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. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

Authorization to Release Information

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any QBE company, its employees, and authorized agents for the purpose of validation and determining benefits payable. I further authorize any QBE company to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

Payment Authorization

I authorize al current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

Signature (Parent or guardian, if the claimant is a minor) | **Date**

X