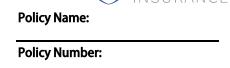
IMPORTANT NOTICE:
This insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

Health Special Risk, Inc.

HSR Plaza II 4100 Medical Parkway Carrollton, Texas 75007 Phone: (972) 512-5600 Fax: (972) 512-5820 Toll Free (800) 328-1114



3. MAIL OR EMAIL TO HSR E-mail: claims@hsri.com

1. PLEASE FULLY COMPLETE THIS FORM 2. ATTACH ITEMIZED BILLS

	PART I - POLIC	CYHOLDER & INSURED	
1. Promoter/Team/League Name		2. Policy Number/Class Code	
3. Claimant - Last Name, First Name		4. Claimant Social Security Number	
5. Mailing Address where Insurance Info/Requests should be mailed		6. City, State, Zip	
7. Birthdate	8. Male 🗖 Female 🗖	9. Phone	10. Email
	INJURY - Please Complete this Section	on to report an Injury	
11. Date of Injury 12. Time & Address where occurred?			13. Part of body injured
14. How did injury occur (description of incident)?			15. Date of first medical treatment
16. Type of Sport (if applicable):		17. Sport Designation: Practice	Game Event Other
18. Action Taken: Released to Parent Ambulance T	ransport 🗖 Referred to Hospital/Clinic 🗖 Own Acco	ord (Adult) 🔲 Other	
19.Claimant Designation: 🔲 Coach/Manager 🔲 Volunteer 🗬 Participant 🗖 Umpire/Referee 🚨 Other			
Was the claimant supervised when injured? Yes No No 21. Was injury during travel to or from scheduled activity in a supervised group? Yes No D			
22.Signature of Policyholder: Date			
PART II — PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)			
1. Father/Guardian Name		9.Mother/Guardian Name	
2.Home Address (Street, City, State, Zip)		10.Home Address (Street, City, State, Zip)	
3.Telephone 4	.Email	11. Telephone	12. Email
5. Employer		13. Employer	
6.Father's Employer Address (Street, City, State, Zip)		14.Mother's Employer Address (Street, City, State, Zip)	
7. Business Phone		15.Business Phone	
8. Employer Medical Insurance Policy		16.Employer Medical Insurance Policy Address:	
(8a) Policy Number:			
(8c) Is Claimant covered under that policy? Yes 🖵 No 🗖			
		RANCE VERIFICATION	
Is Claimant covered by any other insurance policy (other than this		•	0 🗖
If yes, Policy Number:Name of Insurance Carrier:Address of Insurance Carrier:			
	that if other insurance exists, all cl	aims must be submitted to that	other insurance policy first.
I hereby authorize any hospital, policyholder, physician, e injury, policy coverage, medical history, consultations, pre above information is true and correct to the best of my kn with the intent to	mployer, or other person who has attended or exami scription or treatment, and copies of all hospital or m owledge and understand that it is a criminal offense t	ned the Claimant to disclose when requested to nedical records and itemized bills. A copy of this to knowingly file a statement of claim containing	do so, any information to HSRI CLAIMS or POLICYHOLDER with respect to any authorization shall be considered as valid as the original. I swear that the false or misleading information or to willfully conceal information thereto
AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby reasonable and customary charge for those services.	, , , , , , , , , , , , , , , , , , , ,	e for medical benefits, if any, otherwise payabl	

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.