Athlete's Name:__________________ Social Security #:____ ____ ____

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 IL	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 divorce 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 all 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