III. CLAIMS ADMINISTRATION

Insurance Providers:

General Liability Insurance:
Arch Insurance Company
American Specialty Insurance & Risk Services, Inc.
7609 W. Jefferson Blvd., Suite 150
Ft. Wayne, IN 46804-4133
Direct Phone: 260-755-7275
Main Phone: 260-969-5203
Fax: 260-969-4729
Claims Representative: Jeff Jacobson
E-Mail: JJacobson@americanspecialty.com

Sport Accident Insurance:
QBE Insurance Corporation
A-G Administrators, LLC
P.O. Box 979
Valley Forge, PA 19482
Phone: 610-933-0800
Fax: 610-935-2860
Email: claims@agadm.com

Broker/Risk Management:
EPIC Entertainment & Sports
2727 Paces Ferry Road
Building Two, Suite 1500
Atlanta, GA 30339
Phone: 678-324-3300
Fax: 678-324-3303
Email: sport@epicbrokers.com

TABLE OF CONTENTS

USA VOLLEYBALL EVENT POLICY - CLAIMS ADMINISTRATION

I) SPECTATOR & PARTICIPANT LIABILITY

A. INFORMATION TO BE OBTAINED BY THE TOURNAMENT DIRECTOR, CLUB DIRECTOR OR COACH

The Tournament Director, Club Director, Coach or USA Volleyball Representative shall obtain and record the information, immediately at the scene of, or upon notice of, an incident resulting in bodily injury or property damage, to complete the incident report.

The **USA Volleyball Incident Report form should be completed** in its entirety and **emailed, mailed or faxed within 48 hours to the Regional Volleyball office** who will provide a signed copy to American Specialty. In addition, any claim involving serious bodily injury, death or property damage should be sent immediately to the Regional Volleyball office, American Specialty and EPIC. The reports must be submitted **as the incidents occur**. See the Directory on page 3 for contact information.

If the appropriate USA Volleyball Incident Report is not available at the time of the incident, the following minimum information should be documented and forwarded to the Regional Volleyball office as quickly as possible.

1. Name, address and phone numbers of all individuals involved. Include your name and phone number.
2. A complete description of how the incident occurred from the third party involved and any witnesses, including officials or volunteers, acquainted with the facts.
3. Any other information which may assist in handling of any potential claim.
4. If the incident involves injury to a participant, a Sport Accident Excess Medical claim form shall be provided to the participant for completion and submittal to American Specialty.
5. The name of the Region in which the incident occurred, including the Club name and Tournament, if the incident occurred during a tournament.

For any incidents reported without receipt of a formal completed incident report form, the Region should send a blank copy of the incident report form to be completed and returned by the club or event as a follow-up procedure and to ensure consistent collection of sanctioned event incident details.

B. REPORT TO EPIC

IMMEDIATELY (Within 24 hours)

Please notify EPIC immediately by email, fax or phone of the following:

1. The receipt of any legal document/notice of third party liability such as a LAWSUIT or SUMMONS.
2. Property damage in excess of $10,000.

All other incidents or claims should be reported within 48 hours.

C. HANDLING OF INCIDENT REPORTS

Club Directors, Coaches, USAV Representatives shall be required to submit incident reports on ALL INCIDENTS that occur that give rise to bodily injury or property damage losses.

Incident Report forms & related correspondence should be submitted to the appropriate party as follows:

Incident report forms should be submitted to the Regional Volleyball office who in turn will remit the form to both American Specialty and to A-G Administrators. Medical claim forms should be completed by the injured party and submitted directly to A-G Administrators (due to privacy reasons).

When the incident reports have been submitted to American Specialty and to A-G Administrators, they will process the claims as appropriate based on the information remitted.

a) **For liability claims**, If American Specialty determines that a liability claim DOES exist, they;

1) Will do preliminary investigation and will establish a claim reserve, if appropriate.

2) Will take all necessary steps if an actual claim is received.

3) May recommend to USA Volleyball (or the appropriate insured party) an attorney assignment in the jurisdiction in which the incident occurred.

b) If American Specialty determines that a liability exposure DOES NOT exist:

1) The Claims Representative for American Specialty will log the incident as received and no further action will be taken unless a subsequent claim is filed.

D. INVESTIGATING AND SETTLING OF CLAIMS

American Specialty reserves the right to handle the adjustment of the liability claim. USA Volleyball, the Regions, clubs and/or and EPIC (where appropriate) shall provide American Specialty with all information relating to the incident and, when requested, will assist American Specialty in the settlement of the claim.

E. CLAIMS FOLLOW-UP

3. USA Volleyball will be updated as to the status of claims on an annual basis or as requested.

4. Any additional documentation received by USA Volleyball which pertains to General Liability claims should be mailed to the claims representative at American Specialty with a copy to the appropriate Region. In addition, any phone calls, which concern these claims, may be directed to:

American Specialty Insurance & Risk Services, Inc.
Claims Representative: Jeff Jacobson
Phone: 800-245-2744 or 260-755-7275
E-Mail: JJacobson@americanspecialty.com

5. Any difficulties or questions which USA Volleyball may have regarding the claims process or on specific claim, may also be directed to Amee Arledge of EPIC for research.

B. **UPON RECEIPT OF ANY DOCUMENT OR NOTICE OF THIRD PARTY LIABILITY (I.E., SUBROGATION DEMAND, REQUEST FOR PAYMENT FROM PARTICIPANT/SPECTATOR, LAWSUIT), USA Volleyball, the Region, its Tournament Directors, Club Directors or Coaches shall FORWARD such document to EPIC IMMEDIATELY.**

EPIC will forward the information to American Specialty who will match this notice of claim to the original USA Volleyball Incident Report and will handle the claim.

III) SPORT ACCIDENT EXCESS MEDICAL COVERAGE

A. MEDICAL CLAIM FORM

1. As soon as possible, but not later than 90 days, the injured Participant must complete in its entirety and sign the MEDICAL CLAIM FORM and forward the form to A-G Administrators. The form is located under **USAVolleyball.Org**.

A-G Administrators, LLC
P.O. Box 979
Valley Forge, PA 19482
Claims Fax Number: 610-935-2860
Customer Service Number: 610-935-2860
Email: claims@agadm.com

B. CLAIMS FOLLOW-UP

EPIC will receive payment updates, as well as claims status information, on medical claims from the insurance carrier on a periodic basis.

1. EPIC will update USA Volleyball as to the status of Sport Accident (medical) claims on an ANNUAL basis.

2. Any additional documentation, which is received by USA Volleyball, the Region or Club and pertaining to Sport Accident claims, shall be mailed to the Claims Representative at A-G Administrators In addition, any phone calls concerning these claims, shall be directed to the A-G Administrators for direct communication.

3. Any questions regarding the group Sport Accident claim process or concerns regarding the insurance carrier's service may be directed to Sean Lankie at EPIC Entertainment & Sport.

*****IMPORTANT*****

BEHIND THE "CLAIM REPORTING PROCEDURES" YOU WILL FIND AN INCIDENT REPORT AND A MEDICAL CLAIM FORM.

The Incident Report needs to be completed **each** and **every** time a "bodily injury" or "property damage" loss occurs to a spectator, participant or to the facility itself. Each Tournament Director, Club Director or Coach should be given a supply of these Incident Reports and the forms should travel with them to each practice or event. The Directors and Coaches need to be advised of the importance of completing these reports on behalf of USA Volleyball whenever a bodily injury or property damage incident occurs. The Incident Report will enable USA Volleyball to curtail or prevent fraudulent claims from being paid unnecessarily by matching an Incident Report to each claim for damages submitted. If an Incident Report cannot be matched to a claim, the claims representative will know to more thoroughly investigate the claim to determine if the loss really did arise out of a USA Volleyball event. The ability of USA Volleyball to minimize fraudulent claims will help retain the lowest insurance costs possible.

The Medical Claim Form should be provided to a participant who sustains an injury while practicing for or participating in an approved or sanctioned event. Tournament Directors, Club Directors or coaches should keep a supply of these forms on hand at each practice or event. The Medical Claim Form is to be completed by the injured participant and sent directly to **A-G Administrators.**

If the claims reporting system works as intended, A-G Administrators will be in receipt of both an Incident Report from the appropriate Regional Volleyball office describing the incident causing injury and a Medical Claim Form from the injured Participant requesting reimbursement for the medical claim. When they receive both the Incident Report Form and the Medical Claim Form for the same incident, they know there is validity in the claim.

Should you have any questions concerning claims handling, please contact:

Sport Accident-Excess Medical:
A-G Administrators Claims Department:
610-933-0800
claims@agadm.com

General Liability Claims:
Jeff Jacobson @ American Specialty:
260-755-7275
JJacobson@americanspecialty.com

USA VOLLEYBALL
INCIDENT REPORT FORM
INJURY OR PROPERTY DAMAGE

Submit this form to:

SUBMIT THIS FORM TO YOUR REGIONAL VOLLEYBALL OFFICE (ADDRESS ABOVE)

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name **First** **Middle**	**Telephone Number ( )** ☐ **Single** ☐ **Married**
Address	**Social Security Number** _____ _____ _____
City _____ **State**_____ **Zip**_____ **Age**_____ **D.O.B** _____ ____ _____ ☐ **Male** ☐ **Female**	**Employer and Address** _____ _____
Date of Incident _____ **Time of Incident** _____**AM/PM** **Team Name:** _____ **Region**: _____ USAV Membership #: _____	**Does the injured person have other medical insurance?** ☐ **Yes** ☐ **No** If yes, please provide name of company and policy #: _____ **INJURED PERSON:** ☐ Participant ☐ Official ☐ Coach ☐ Spectator ☐ Volunteer ☐ Other: _____

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name **First** **Middle**	**Telephone Number ( )**
Address City State **Zip**	

INCIDENT INFORMATION

BODY PART INJURED

☐ Ankle (L/R) ☐ Shoulder (L/R) ☐ Back
☐ Knee (L/R) ☐ Wrist (L/R) ☐ Neck
☐ Nose ☐ Finger ☐ Internal
☐ Head ☐ Eye (L/R) ☐ No Injury
☐ Tooth ☐ Ear (L/R) ☐ Other

If Ankle Injury, was ankle
☐ Taped ☐ Supported
☐ Unsupported
Shoes: ☐ Yes ☐ No

If Knee Injury, was knee:
☐ Braced ☐ Supported
☐ Unsupported
Knee Pads: ☐ Yes ☐ No

INCIDENT

☐ Collision (participant/spectator)
☐ Collision (with object)
☐ Collision (participant/participant)
☐ Collision (spectator/spectator)
☐ Struck by falling/flying object
☐ Caught in, on, between
☐ Animal/insect bite/sting
☐ Slip/Fall
☐ Overexertion
☐ Assault/Sexual
☐ Assault/Non-Sexual
☐ **Property Damage**

COURT SURFACE

☐ Concrete ☐ Asphalt
☐ Grass ☐ Sand
☐ Wood ☐ Sport Court

If sport court, what is under-lying surface?
☐ Wood
☐ Concrete ☐ Asphalt

CLASSIFICATION

☐ Non-injury
☐ Minor injury or illness
☐ Serious injury or illness

INCIDENT LOCATION

☐ Before Competition/Event
☐ During Competition/Event
☐ After Competition/Event

☐ Competition area
☐ Concession area
☐ Parking lot
☐ Admission area
☐ Restrooms/locker rooms
☐ Off property
☐ Bleachers/stands

PRIMARY INJURY

☐ Allergy ☐ Dislocation
☐ Amputation ☐ Nausea
☐ Foreign Body ☐ Burn
☐ Laceration ☐ Fracture
☐ Heat Exhaustion ☐ Pain
☐ Hypertension ☐ Cardiac
☐ Cold Injury ☐ Contusion
☐ Electrical Shock ☐ Seizures
☐ Strain/Sprain ☐ Concussion
☐ Abrasion ☐ Sting/bite
☐ Illness ☐ Death

DISPOSITION

No care given:
☐ Patient refused
☐ Not needed
Released:
☐ To parent
☐ To personal vehicle

Referral
☐ To doctor
☐ To hospital/clinic

EMS transport:
☐ Trainer recommended
☐ Patient/parent quested

Describe how the injury or property damage occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

Name	Address	Telephone Number
1.		( )
2.		( )

Tournament Director, Club Director, Coach and/or USA Volleyball Official completing this form:

Name: _____ **Signature:** _____

Title: _____ **Date:** _____ **Phone #:** (_____)_____

Event Name: _____

Event Location: _____

Sanctioning Region: _____ **Region Signature:** _____

A-G ADMINISTRATORS, LLC
P.O. Box 979
Valley Forge, PA 19482
P: 610.933.0800 | F: 610.935.2860
www.agadministrators.com

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits to:
claims@agadm.com
For questions, please contact A-G Administrators.

USA VOLLEYBALL MEDICAL CLAIM FORM

This form should be completed whenever claim results from an injury incurred at USA Volleyball sanctioned events.
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

NAME *(Last Name)* *(First Name)* *(Middle Initial)*	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH**	**SEX** ☐ M ☐ F

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

TELEPHONE NUMBER:	**OCCUPATION:**
USA VOLLEYBALL PARTICIPANT #:	**DATE & TIME OF ACCIDENT:**

INJURED PARTY WAS: ☐ PARTICIPANT ☐ COACH ☐ OFFICIAL ☐ VOLUNTEER ☐ OTHER: _____

IF PARTICIPANT, MEMBERSHIP TYPE: ☐ JUNIOR MEMBER ☐ ADULT MEMBER ☐ NATIONAL OR HIGH PERFORMANCE TEAM MEMBER

REGIONAL ASSOCIATION NAME:	**COACHES NAME:**	**PHONE #:**

NATURE OF INJURY *For all injuries, please complete the following:*

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT: _____

_____

B. DESCRIBE WHERE ACCIDENT HAPPENED: _____

_____

C. DESCRIBE HOW ACCIDENT HAPPENED: _____

_____

D. DID THE ACCIDENT OCCUR DURING:

☐ COMPETITION ☐ PRACTICE ☐ TRAVELING TO/FROM ☐ OTHER: _____

E. WITNESS NAME: _____ PHONE #: _____

IF INJURED PARTY IS A MINOR:

PARTENT/GUARDIAN NAME: _____ HOME PHONE #: _____

EMPLOYER NAME: _____ WORK PHONE #: _____

IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? ☐ YES ☐ NO

IF YES, NAME OF INSURANCE COMPANY:	POLICY NUMBER:

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to A-G Administrators, LLC, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.

NAME OF PATIENT	SIGNATURE OF PATIENT *(parent/guardian if a minor)*	DATE

I certify that the foregoing information is true and correct.	SIGNATURE	DATE

The completion of this form is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.

USA VOLLEYBALL
MEDICAL CLAIM FILING INSTRUCTIONS

1. DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA VOLLEYBALL.
2. Make sure the injury has been reported to your Regional Volleyball Association.
3. Complete claim form in full. Use an additional sheet if necessary.
4. Either notify medical providers of excess coverage for services related to injury by providing the below mentioned contact information or attach itemized physician, hospital or other providers' standard insurance billing forms: CMS-1500 from physician or UB-04 from Hospital; these forms must show the following:
    - Patients Name
    - Condition/Diagnosis
    - Type of Treatment
    - Date expense incurred
    - Charges
5. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Armed Forces or other coverage. If you wish for payment to be made to you, then you must provide proof of payment from the provider.
6. To expedite proper processing, submit form complete in full along with the above documents to the following address:

A-G ADMINISTRATORS, LLC
P.O. Box 979
Valley Forge, PA 19482
P: 610.933.0800 | F: 610.935.2860
www.agadministrators.com
claims@agadm.com

IMPORTANT CLAIM NOTICE

Alaska: A person who knowingly 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: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas or Louisiana: 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.

California: For your protection California law requires the following to appear on this form. 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.

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.

Delaware: Any person who knowingly, 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.

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.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information, commits a felony.

Kentucky: Any person who knowingly 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.

Maine, Tennessee or Virginia: 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 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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. (PURSUANT TO 11 NYC RR86)

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. 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.

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.

Puerto Rico: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

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.

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.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

SIGNATURE OF INJURED PERSON *(parent/guardian if a minor)*

DATE