



To file an injury claim:

USA Boxing's sports accident policy provides medical coverage only for injuries due to boxing in organized training or sanctioned competition. There is a \$1,000 deductible (if you have primary medical insurance) or a \$2,500 deductible if you do not have primary insurance. These deductibles are the responsibility of the injured individual. Do not file claims for injuries other than those from boxing, or for treatment costing less than the deductible you are responsible for (\$1,000 or \$2,500) Illness is NOT a covered condition.

When an injury occurs, treatment must commence within 30 days after the accident and the claim must be filed within 60days.

Insurance forms that need to be filled out and/or signed:

USA Boxing Injury Report

USA Boxing Medical Claim Filing Instructions and USA Boxing Medical Form

Complete the entire injury report, including your membership number (found in your passbook or on your membership card), your social security, the date of injury, and a complete description of how and where the injury happened. The injury report must be signed by an official at the event or by your coach if it happened in the gym.

If you carry insurance coverage other than USA, please give policy information for your primary insurance (or write "None" if you don't). Make sure you provide your mailing address, signature and date the form.

Return the completed claim forms to:

USA Boxing  
1 Olympic Plaza  
Colorado Springs, CO 80909

USA Boxing will review the forms for completeness and forward to the insurance company. Incomplete forms will be returned to the individual, as well as bills from health care providers. Insurance claims adjusters, not USA Boxing, will accept or deny your claim.

Specific questions about your claim should be directed to the insurance company.

Failure to provide all required information will result in delays in processing the claim. USA Boxing is not responsible for payment of your medical bills.

# USA BOXING INJURY REPORT

Use this form for ANY injury to spectator as well as athlete and non-athletes  
(Check and/or circle one per section, complete relevant blanks)



Injured: (Member) (Spectator) (Other: \_\_\_\_\_ )  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: (M) (F)  
 Parents Name (If minor): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Sanction #: \_\_\_\_\_ Member's Reg. #: \_\_\_\_\_  
 Member's Reg. Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Name of Location Where Injury Occurred: \_\_\_\_\_  
 Name of Local Boxing Committee: \_\_\_\_\_

INJURY:	TIME:	DISPOSITION:
Date of Injury: _____	<input type="checkbox"/> Morning	<input type="checkbox"/> Ringside Physician Attention
Injured Body Part: _____	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Auto to Hospital
Condition: _____ (Sprain, Fracture, Concussion, etc.)	<input type="checkbox"/> Evening	<input type="checkbox"/> Ambulance to Hospital
Estimated absence from boxing (1-7 days) (1-3 weeks) (3+ weeks)		

OCCASION:	ACTIVITY:	SITUATION:
<input type="checkbox"/> During supervised practice Name of supervising coach _____ <input type="checkbox"/> In sanctioned competition Round _____ <input type="checkbox"/> Other: _____ Weight Class: _____	<input type="checkbox"/> Sparring <input type="checkbox"/> Bag / Pad work <input type="checkbox"/> Rope Jumping <input type="checkbox"/> Weights <input type="checkbox"/> Calisthenics <input type="checkbox"/> Road work <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hit by opponent <input type="checkbox"/> Hit opponent <input type="checkbox"/> Fell (pushed) (slipped) (tripped) (lost balance) <input type="checkbox"/> Other: (Describe fully below)
PROGRAM:	LOCATION:	PROTECTIVE EQUIPMENT:
<input type="checkbox"/> USA Boxing <input type="checkbox"/> Golden Gloves <input type="checkbox"/> Silver Gloves <input type="checkbox"/> PAL <input type="checkbox"/> NCBA <input type="checkbox"/> Intl Club Exchange <input type="checkbox"/> Other: _____	<input type="checkbox"/> Locker room <input type="checkbox"/> Ring <input type="checkbox"/> Gym floor <input type="checkbox"/> Spectator area <input type="checkbox"/> Other: _____	Wearing mouthpiece? (yes) (no) Wearing headgear? (yes) (no)

**DESCRIBE HOW INJURY HAPPENED:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Local Boxing Committee Officer validating injury claim: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_



# USA BOXING MEDICAL CLAIM FILING INSTRUCTIONS

- MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA BOXING.
- Complete claim form in full. Use an additional sheet if necessary.
- Attach current itemized physician, hospital or other providers' standard insurance billing forms: HCFA from physician or UB 92 from Hospital. These forms must show the following:
  - Patients Name
  - Type of Treatment
  - Charges
  - Condition/Diagnosis
  - Date expense incurred
- 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), Medicare, Medicaid, Armed Forces or other coverage.

- To expedite proper processing, submit form complete in full along with the above documents to

**USA BOXING (First Report):**  
 United States Amateur Boxing, Inc.  
 1 Olympic Plaza  
 Colorado Springs, CO 80909  
 Phone Number (719) 866-2311  
 Fax Number: (719) 632-3426

**Future bills should be sent to:**  
 NAHGA Claim Services  
 P.O. Box 189  
 Bridgton, ME 04009  
 Phone Number: (800) 952-4320  
 Fax Number: (207) 647-4569



### Important Fraud Notice

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files 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 are provided by the claimant.

Signature of injured person (or parent/guardian if minor)

Date

# USA BOXING MEDICAL CLAIM FORM



Send this form to:  
USA Boxing  
1 Olympic Plaza  
Colorado Springs, CO 80909

This form to be completed whenever a medical claim results from an injury incurred at USA Boxing sanctioned event.  
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY					
NAME (Last Name) (First Name) (Middle Initial)			SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS (Street) (City) (State) (Zip Code)			TELEPHONE NUMBER ( )	OCCUPATION	
USA BOXING MEMBERSHIP #:			DATE & TIME OF ACCIDENT: / / AM PM		
INJURED PARTY WAS: <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> OTHER: _____ IF PARTICIPANT, MEMBERSHIP TYPE (PLEASE CHECK ALL THAT APPLY): <input type="checkbox"/> ANNUAL MEMBER <input type="checkbox"/> FOREIGN ATHLETE					
NAME OF EVENT:			LBC OR CLUB REPRESENTATIVE	PHONE #: ( )	
NATURE OF INJURY			SIGNATURE OF AUTHORIZED USA BOXING NATIONAL HEADQUARTERS REP.		
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: <input type="checkbox"/> COMPETITION <input type="checkbox"/> PRACTICE <input type="checkbox"/> TRAVELING TO/FROM <input type="checkbox"/> OTHER: _____					
E. WITNESS NAME: _____ PHONE #: _____					
IF YOU HAVE NO OTHER INSURANCE COVERAGE (IF UNEMPLOYED OR HAVE NO SPOUSE, PLEASE INDICATE SAME):					
EMPLOYER NAME, ADDRESS AND TELEPHONE NUMBER: _____					
SPOUSE EMPLOYER NAME, ADDRESS AND TELEPHONE NUMBER: _____					
IF INJURED PARTY IS A MINOR AND YOU HAVE NO INSURANCE COVERAGE ON YOUR CHILD (IF UNEMPLOYED, PLEASE INDICATE SO UNDER EMPLOYER NAME):					
FATHER- PARENT/GUARDIAN NAME: _____			HOME PHONE #: _____		
EMPLOYER NAME: _____			WORK PHONE #: _____		
MOTHER-PARENT/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 OR AUTOMOBILE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IS THE INJURED PERSON COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, What is your Health Insurance Claim Number? _____					
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 NAHGA Claim Services, 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
AUTHORIZATION TO PAY PROVIDER - I authorize payment associated with this incident directly to the physicians or providers.			IF YES, SIGNATURE		DATE
I certify that the foregoing information is true and correct.			SIGNATURE		DATE

The issuance of this blank 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.