

MAIL CLAIM FORM TO:
MACORI ADMINISTRATION
 c/o **MACORI, INC.**

NOTIFICATION OF INJURY

Policy Number

dba **MAKSIN MANAGEMENT CORP.**
 P.O. Box 2508, SPRING, TX 77383-2508
 Phone: (281) 651-8787 Houston Area
 (800) 285-8133 Outside the Houston Area
 Fax: (281) 651-8808

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.

FOR OFFICE USE	
Reference Number	
Coverage Code	

FORM MUST BE COMPLETED IN FULL & MAILED TO OUR OFFICE WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT

PART I – ACCIDENT REPORT

1A. Name of School		1B. Name of School District/Diocese/Association				
2A. Name of Student (Last)	(First)	(Middle Initial)	2B. Social Security No.	2C. Grade	2D. Birthdate	2E. Sex
3. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)						
4. Describe how accident occurred. (Please provide all details.) MUST BE A BODILY INJURY DUE TO AN ACCIDENT.						
5A. Was the accident school-related? <input type="checkbox"/> Yes <input type="checkbox"/> No			5B. Is the accident covered under a catastrophic policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6A. Did Accident Occur:		Yes	No	6B. a) Date of Accident		6C. Name of Activity
a) while the claimant was supervised?		<input type="checkbox"/>	<input type="checkbox"/>	b) Time		6D. Name and Title of Supervisor
b) during sponsored activity?		<input type="checkbox"/>	<input type="checkbox"/>	c) Place		
c) during programmed hours?		<input type="checkbox"/>	<input type="checkbox"/>			
d) on activity premises?		<input type="checkbox"/>	<input type="checkbox"/>			
e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities?		<input type="checkbox"/>	<input type="checkbox"/>			
7A. _____		7B. _____		7C. _____		
Signature of School Officer		Title		Date		

PART II – TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)

1A. Name of Father/Guardian or Claimant (if adult) <input type="checkbox"/> None	1B. Social Security No.	1C. Address/City/State/Zip	1D. Phone Number
2A. Name of Mother/Guardian or Spouse (if adult) <input type="checkbox"/> None	2B. Social Security No.	2C. Address/City/State/Zip	2D. Phone Number
3A. Name of Father/Guardian's or Claimant's (if adult) Employer <input type="checkbox"/> None	3B. Address/City/State/Zip of Employer		3C. Phone Number
4A. Name of Mother/Guardian's or Spouse's (if adult) Employer <input type="checkbox"/> None	4B. Address/City/State/Zip of Employer		4C. Phone Number
5A. List all Insurance Company(ies) under which the claimant is insured <input type="checkbox"/> None	5B. Policy Number(s)	5C.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	
_____	_____	<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.	

Affidavit: I verify that the above information regarding 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.

_____	_____
Signature of Parent/Guardian or Claimant (if adult)	Date
Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.	
_____	_____
Signature of Insured (Parent or Guardian if claimant is under 18)	Date