MAPP

As a member benefit, Sigma Tau Gamma Fraternity purchases the Member Accident Protection Policy (MAPP.) MAPP coverage is for current active undergraduate members and associate members. On the date of injury a member must be currently enrolled in the university where his chapter is located and in good standing with the Fraternity to qualify for coverage.

MAPP is **not** a substitute for health insurance. Health insurance protects against illness as well as injury. MAPP is supplemental coverage for injury only.

Most health insurance plans require the insured to pay a portion of the treatment cost. Plan co-pay and deductible provisions define the amount.

MAPP reimburses a member for the co-pay and/or deductible amounts incurred from a covered injury. Claims must be made within 180 days of the date of injury. The policy limit is $100,000.

Follow directions on the claim form. Send the completed form with appropriate signatures and supporting itemized bills to the claims administrator identified on the form. Address all inquiries to the administrator or call the toll-free number on the form.

Please note this coverage is subject to certain exclusions and limitations. The description of benefits under the policy outlined above is not an admission of coverage under the plan. In the event there are issues pertaining to your right for coverage under the plan, the administrator will promptly advise you of the same.

Return Completed form to:
Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032
P: 877-444-5009
F: 317-575-2256
Markel.claims@sevencorners.com

Fraternity/Sorority Member Accident Protection Program Claim Form

Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number above.

In order to pay claims we must have your Social Security Number

Member Coverage Information and Initial Claim Reporting Call 877-444-5009

Part 1- INJURED MEMBER REPORT

Name of (Inter)national Fraternity/Sorority	College or University Where Chapter is Located			Policy Number **4102AH257695-10**
Name of Injured Person	Social Security Number (Required)	Gender ☐ Male ☐ Female	Date of Birth	E-mail Address
Injured Person's Address	City	State	Zip	Phone Number
Parent's Names (if applicable)	Parent's Address (if applicable)	City	State	Zip / Phone Number

1. Date and time of accident:_____ Place where the accident occurred:_____

FOR DENTAL CLAIMS ONLY

2. Indicate which teeth were involved in the accident:_____

3. Describe condition of injured teeth prior to accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

4. Nature of Injury:_____
(indicate part of body injured- e.g. broken arm, sprained ankle, etc.)

5. Describe how the accident occurred- give all possible details- must be a bodily injury due to accident:

_____

6. Did the accident occur :

A. During a fraternity organized activity?	☐ Yes	☐ No
B. On fraternity owned or leased property?	☐ Yes	☐ No
C. While on the job (if applicable)?	☐ Yes	☐ No
D. During intercollegiate/scholastic athletic practice or competition?	☐ Yes	☐ No
E. During a university or college sponsored activity?	☐ Yes	☐ No
F. Are you currently enrolled in the university or college where your chapter is located?	☐ Yes	☐ No

7. If the injury occurred during a Fraternity sponsored Event, Please provide the name and location of the Event:_____

Part 2- OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health coverage through an employer or other source? ☐ Yes ☐ No

If yes, Name of insurance company_____ Policy #_____
Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐ Yes ☐ No

If Yes, Name of insurance company_____ Policy #_____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE OR HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse Markel Insurance Company to the extent of any amount collectible.

Claimant, Parent or Authorized Representative 's Signature: _____ Date:_____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

Claimant, Parent or Authorized Representative 's Signature: _____ Date:_____

If Authorized Representative, Relationship to Patient or Legal Designation:_____

I AUTHORIZE any insurance company, hospital, physician, medical care provider,clinic, medical care facility, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.
I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative 's Signature: _____ Date:_____

If Authorized Representative, Relationship to Patient or Legal Designation:_____

TO BE COMPLETED BY PROGRAM ADMINISTRATOR

Signature of Program Administrator: _____ TITLE: _____ Date: _____

PLEASE NOTE

In furnishing this or other claim forms for the convenience of the claimant, MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any 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: 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 RESIDENTS: 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.

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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

RHODE ISLAND: 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.

TENNESSEE: 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.

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.

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 denial of insurance benefits.

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.

WEST VIRGINIA: 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.