

COMPLETE AND SEND THIS FORM TO:

ACCIDENT PROOF OF LOSS/CLAIM FORM

New Jersey Youth Soccer Association
569 Abbington Drive Suite 5
East Windsor, NJ 08520



\$100.00 Deductible

104 week eligibility period

Please read instructions on Page 3 before completing this form
SECTION I - TO BE COMPLETED BY CLAIMANT PARENT OR GUARDIAN - Required

1. **NAME:** (first) _____ (last) _____

2. **ADDRESS:** _____ (city) _____ (state) _____ (zip code) _____

3. **TELEPHONE:** _____ **BIRTHDATE:** ___/___/___ **GENDER:** Male Female

4. **CLAIMANT IS A:** Player [Include a copy of the player's pass with this claim] Coach Official Other

5. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ am pm

6. **BODY PART INJURED:** _____

7. **ACCIDENT OCCURRED DURING:** Game Practice Tournament Camp/Clinic

8. **IF ACCIDENT OCCURRED AT A TOURNAMENT, NAME OF TOURNAMENT:** _____

9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:** _____

10. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:** _____

SECTION II - STATISTICAL INFORMATION - Required

NAME OF LEAGUE/CLUB/TEAM: _____

NAME OF OPPONENT (If during game or tournament) _____

TYPE: COMPETITIVE RECREATIONAL

LOCATION: ON FIELD SIDELINES SPECTATOR AREA OTHER

SURFACE: DIRT GRASS OUTDOOR TURF INDOOR TURF

SURFACE CONDITION: DRY/NORMAL WET/RAINY ICY MUDDY

POSITION: _____

STATUS: HIT BY OBJECT COLLISION W/OPPONENT COLLISION W/TEAMMATE

OTHER _____

SECTION III - To Be Completed By New Jersey Youth Soccer - Only

POLICY EFFECTIVE DATE September 1, 2007	POLICY EXPIRATION DATE September 1, 2008	POLICY # PST2461C	NAME OF POLICYHOLDER New Jersey Youth Soccer Association
ADDRESS OF POLICYHOLDER 569 Abbington Drive, Suite 5 East Windsor, NJ 08520			TELEPHONE NUMBER 609-490-0725

Verify that the accident occurred during an activity sponsored or sanctioned by New Jersey Youth Soccer and whether claimant was a member at the time of the accident

YES-Sponsored/Sanctioned Activity

YES-Claimant Was Active Member On Date Of Accident

I certify that the foregoing information is true and correct.

New Jersey Youth Soccer

Title

Date

SECTION IV - STATEMENT OF OTHER INSURANCE (Required)

Relationship to Claimant: (Circle One)
Self Father Mother Guardian Spouse

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
EMPLOYER: _____
EMPLOYER PHONE: _____

Employed Self-Employed Unemployed

Relationship to Claimant: (Circle One)
Self Father Mother Guardian Spouse

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
EMPLOYER: _____
EMPLOYER PHONE: _____

Employed Self-Employed Unemployed

(If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.)

Is Claimant a member of another youth soccer organization? YES NO Name: _____

Is Claimant Covered Under Any Other Medical And Or Dental Insurance Policy? YES NO

Is Claimant Covered Under A Government Sponsored Insurance Such As Medicare/Medicaid? YES NO

INSURED NAME: _____ ID#: _____ INSURED GRP#/NAME: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

Note: If the injured has medical coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party:

SECTION V - ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

SECTION VI - STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantial civil penalty to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT (required): _____ DATE: _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT (required): _____ DATE: _____

IMPORTANT
ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Accident medical expense coverage** under this policy is provided on an Excess Basis and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (e.g. to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment.
2. **Claim Guidelines:** You have 90 days from date of injury to submit claim form. For claims to be eligible for coverage you must seek medical attention within 60 days from date of injury.

Benefit Period: This policy is subject to a **104 week** eligibility period from date of injury. Medical or dental expenses that are incurred **within 104 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **104 week** benefit period will not be covered by this policy.

3. **Please remember:**

- a) New Jersey Youth Soccer must complete Section III of the claim form.
 - b) Please make sure you have completed the entire claim form and signed where required.
 - c) Advise your Providers/Hospitals of this insurance so they can file claims directly to Bollinger
 - d) Attach all Explanation of Benefits (EOB) forms that you have received from your Primary Insurance carrier or other healthcare plan.
 - e) Itemized bills are required. You must submit itemized bills; balance due bills will not be processed. See below for forms needed.
 1. HCFA-1500: standard form used by Providers
 2. UB-04 or UB-92: standard form used by Hospitals
 - f) Payment of bills will follow the **usual and customary guidelines**. This means that the basis for payment of specific medical or dental claims is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.
4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Bollinger Insurance.
 5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HAS):** Please read below and follow the steps appropriately to submit information.
 1. **Employer contribution to flex account** – Primary insurance first, then flex account, then Bollinger
 2. **Employee contribution to flex account** – Primary insurance first, then Bollinger, the flex account. If monies have been paid out of your flex account before Bollinger, then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

For further information contact:

Bollinger, Inc
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-2876
www.BollingerSoccer.com

Send this claim form for authorization to:

New Jersey Youth Soccer Association
569 Abbington Drive Suite 5
East Windsor, NJ 0852
Phone: 609-490-0725
Fax: 609-490-0731
office@NJYouthSoccer.com

