

COMPLETE AND RETURN THIS FORM TO:

ACCIDENT PROOF OF LOSS/CLAIM FORM



1655 S. Arlington Heights Rd, Ste 201
Arlington Heights, IL 60005



\$500.00 Deductible

104 week eligibility period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (Required)

1. NAME: (first) _____ (last) _____
2. ADDRESS: _____ (city) _____ (state) _____ (zip code) _____
3. TELEPHONE #: _____
4. BIRTHDATE: ___/___/___ SEX: Male Female SS#: _____
5. CLAIMANT IS A: Player Coach Official Other
5. ACCIDENT DATE: ___/___/___ ACCIDENT TIME: _____ am pm
6. BODY PART INJURED: _____
7. ACCIDENT OCCURRED DURING: Game Practice Tournament Camp/Clinic Other _____
8. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: _____

9. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: _____

SECTION II STATISTICAL INFORMATION (Required)

1. NAME OF TEAM/CLUB: _____
2. TYPE: COMPETITIVE RECREATIONAL
3. LOCATION: ON FIELD SIDELINES SPECTATOR AREA OTHER
4. SURFACE: DIRT GRASS OUTDOOR TURF INDOOR TURF
5. SURFACE CONDITION: DRY/NORMAL WET/RAINY ICY MUDDY
6. POSITION: _____
7. STATUS: HIT BY OBJECT COLLISION W/OPPONENT COLLISION W/TEAMMATE
 OTHER _____

SECTION III TO BE COMPLETED BY AUTHORIZED OFFICIAL (Required)

POLICY EFFECTIVE DATE September 1, 2011	POLICY EXPIRATION DATE September 1, 2012	POLICY # 4102AH023483	NAME OF POLICYHOLDER Illinois Youth Soccer Association
ADDRESS OF POLICYHOLDER (Street) 1655 S. Arlington Heights Road, Suite 201	(City) Arlington Heights	(State) IL 60005	TELEPHONE NUMBER 847-290-1577
VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT. <input type="checkbox"/> YES-SPONSORED/SANCTIONED ACTIVITY <input type="checkbox"/> YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT			
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.			
AUTHORIZED SIGNATURE:		TITLE:	DATE:

SECTION IV**STATEMENT OF OTHER INSURANCE****(Required)****Father/Claimant****Mother/Claimant**

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

CITY: _____

CITY: _____

STATE: _____ ZIP: _____

STATE: _____ ZIP: _____

PHONE: _____

PHONE: _____

EMPLOYER: _____

EMPLOYER: _____

PHONE: _____

PHONE: _____

SELF EMPLOYED UNEMPLOYED SELF EMPLOYED UNEMPLOYED

EMAIL: _____

EMAIL: _____

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NOIS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES NO

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

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

Please include copy of Insurance card (both sides)*Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE 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/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/CLAIMANT (required): _____ DATE: _____**

HOW TO FILE A CLAIM: INSTRUCTIONS

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

1. **Excess Coverage:** Accident medical expenses are covered under this policy 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 (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. Payment under this policy will be made according to **usual and customary guidelines**. This means that the basis for payment of specific medical or dental services 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.
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** benefit 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) Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
 - b) **Itemized bills are required:** You or your providers must submit itemized bills; balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.
 - **HCFA-1500** is the standard form used by Providers, such as doctors and dentists, to show the medical treatments and charges made for each service.
 - **UB-04 or UB-92** is the standard form used by Hospitals to show medical treatments and charges made for services.
 - Primary Insurance **Explanation of Benefits** (if applicable)
5. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.
6. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.
 - a. Employer contribution to flex account - Send to Primary insurance first, then flex account, then Bollinger
 - b) Employee contribution to flex account - Send to Primary insurance first, then Bollinger, then 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 claims information contact:

Bollinger, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-2673
Email: SportsClaims@BollingerInsurance.com

Send this claim form for authorization to:

Illinois Youth Soccer Association
1655 S. Arlington Heights Road, Suite 201
Arlington Heights, IL 60005
Phone: 847-290-1577
Fax: 847-290-1576

www.BollingerSoccer.com



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.

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.

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.



INSURANCE CLAIM FORM

SUBMIT WITHIN THIRTY (30) DAYS FROM DATE OF INJURY

SUBMIT THIS FORM TO YOUR LEAGUE FOR VERIFICATION BEFORE SENDING TO ILLINOIS YOUTH SOCCER!

Illinois Youth Soccer (IYSA) will not accept, process or pay bills and approve or verify insurance payments. **Incomplete Claims will be returned.** Please complete and submit this IYSA Insurance Claim Form, Youth Soccer Accident Proof of Loss Form, and copy of claimant's IYSA Medical Release & Liability Waiver to the Illinois Youth Soccer Association within thirty(30) days from the date of accident. **Do not include medical bills.** Insurance company will reject all claims that have not been processed and approved by the IYSA. The IYSA will reject all claims that have not been completed and signed by the claimant, verifying coach and affiliated league. Do not wait for the bills before filing a claim with the IYSA. IYSA coverage is secondary if claimant has primary insurance coverage. There is a \$500 deductible. 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 substantial civil penalty where and to the extent allowed by state law.

1. **If you have other insurance, submit your claim and itemized bills to the other carrier immediately.**
2. Have the coach and witness verify accident occurrence by his/her signature where indicated.
3. Obtain your League Officer's signature on the IYSA Claim Form verifying that the claimant was a currently registered player in good standing with his/her league and the IYSA at the time of the accident, that the accident occurred during IYSA affiliated league approved youth soccer activity and that the claimant had IYSA authorization to participate in the IYSA/USYSA sanctioned youth soccer activity in which the claimant was injured
4. Complete and submit to IYSA this IYSA Insurance Claim Form, Insurance and Youth Soccer Accident Proof of Loss Form with verification signatures.
5. **SUBMIT TO IYSA COPY OF CLAIMANT'S IYSA MEDICAL RELEASE & LIABILITY WAIVER WITH CLAIM.**
6. Keep copies of all documents and bills in the event that they are lost in the mail.
7. Incomplete and unsigned forms will be returned to the claimant.
8. The IYSA is not responsible for processing delays due to incomplete, improperly completed or returned claim forms and postal delays.

THIS SECTION TO BE COMPLETED BY CLAIMANT:

Date of Accident _____ Player's Pass No. _____
 Claimant's Name _____ Birthdate _____
 Street Address _____
 City, State, Zip _____
 Home Phone(_____) _____ Parent/Guardian Work Phone(_____) _____ Email _____
 Team Name _____ U- _____ BOYS GIRLS
 Club Affiliation _____ IYSA League Affiliation _____

I, the undersigned claimant or parent/guardian (for a minor) hereby certify that the injury occurred in the indicated Illinois Youth Soccer Association, US Youth Soccer or IYSA affiliated league activity and the information provided in the insurance claim is correct.

Claimant or Parent/Guardian's Signature for a minor _____ Relationship to Minor _____ Date _____

THIS SECTION TO BE COMPLETED & SIGNED BY CLAIMANT'S COACH:

Verifying Coach's Name _____ Team Name _____ U- _____
 Coach's Street Address _____
 City, State, Zip _____
 Home Phone(_____) _____ Work Phone(_____) _____ X
 Email _____

INDICATE ACTIVITY IN WHICH INJURY OCCURRED:

' LEAGUE GAME ' TOURNAMENT ' STATE CUP ' PRACTICE ' Other _____ Date _____
 If injury occurred at Tournament, indicate TournamentName _____
 Tournament Location (City, State) _____ Date _____
 Describe Injury (Indicate left or right leg, foot, etc.) _____
 Describe How Injury Occurred _____

I, the undersigned team coach hereby certify that the claimant's injury occurred in the above listed Illinois Youth Soccer Association, US Youth Soccer, or IYSA affiliated league activity. Verifying Coach's Signature _____ Date _____

THIS SECTION TO BE SUBMITTED TO AFFILIATED LEAGUE NOT IYSA FOR VERIFICATION

League Name _____ League Official _____

By my signature I verify that the claimant is currently registered and in good standing with the above listed IYSA affiliated league.
 League Official's Signature _____ Title _____ Date _____

FOR ILLINOIS YOUTH SOCCER VERIFICATION ONLY

IYSA Official _____ Title _____ Date _____

**SEND COMPLETED FORM TO: ILLINOIS YOUTH SOCCER ASSOCIATION - INSURANCE CLAIM
 1655 S. ARLINGTON HEIGHT ROAD, SUITE 201, ARLINGTON HEIGHTS, IL 60005
 847/290-1577 847/290-1576(F) www.illinoisyouthsoccer.org**