COMPLETE AND RETURN THIS FORM WITH THE IYSA CLAIM FORM TO ILLINOIS YOUTH SOCCER!

P.O. Box 390 Short Hills, NJ 07078

Attn: Insurance Claim Dept.
1655 S. Arlington Heights Road, Suite 201, Arlington Heights, IL 60005

$500.00 Deductible **104 week eligibility period**

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN (Required)

1. **NAME:** (first) ______________________ (last) ______________________
2. **ADDRESS**: ______________________ (city) ______________ (state) _______ (zip code) _______
3. **BIRTHDATE:** ___/___/___ **SEX:** Male Female
4. **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:** ______________________

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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:**	GOALIE	FORWARD	DEFENDER	OTHER __________
7. **ACTIVITY:**	RUNNING W/BALL	RUNNING W/OUT BALL	DEFENDING	OTHER __________
8. **STATUS**:	HIT BY BALL	COLLISION W/PLAYER	COLLISION W/OBJECT	OTHER

SECTION III TO BE COMPLETED BY AUTHORIZED OFFICIAL (Required)

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER
September 1, 2013	**September 1, 2014**	**4102AH023483**	**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.

YES-SPONSORED/SANCTIONED ACTIVITY
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/Guardian/Claimant
NAME: ____________________________________
ADDRESS: __________________________________
CITY: _____________________________________
STATE: ________________ ZIP: ______________
PHONE: ___________________________________
EMPLOYER: ________________________________
PHONE: ___________________________________
SELF EMPLOYED UNEMPLOYED

Mother/Guardian/Claimant
NAME: ____
ADDRESS: ____
CITY: ____
STATE: ________________________ ZIP: ___________________
PHONE: ____
EMPLOYER: ____
PHONE: ____
SELF EMPLOYED UNEMPLOYED

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NO

INSURED NAME: _________________________ ID#: _____________________ INSURED GRP#/NAME: _______________
COMPANY NAME: ____
ADDRESS: ____
CITY: _____________________________________ STATE: ______________________________ ZIP: ___________________
PHONE: ____

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 BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

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 (i.e. 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.
   104-weeks: 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) Please complete the Illinois Youth Soccer Association ("IYSA") Claim form & have it signed by your league.
   b) Please submit the IYSA Claim form & the Bollinger Claim form to Illinois Youth Soccer.
   c) Please submit to the IYSA the claimant's IYSA Emergency Medical Release & Liability Waiver.
   d) Please make sure you have completed the entire claim form and signed where required.
   e) Please attach all itemized bills to this form. Subsequent bills can be sent in as you receive them with no additional claim forms. Each bill must show the following:
      1. Provider's Name, address and phone number
      2. Provider's Federal Tax ID#
      3. Dates of service
      4. Diagnosis Description or Codes (ICD-9)
      5. Procedure Description of Codes (CPT)
      6. Charge for each procedure
   f) Please attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.

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. **Flexible Spending Account:** You must submit your bills through your primary insurance carrier and Bollinger Insurance first before accessing your Flexible Spending Account within your company.

For further information contact:
Bollinger, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
www.BollingerInsurance.com
www.BollingerSoccer.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

Bollinger
Insurance Since 1876