

CLAIM FILING PROCEDURES (for office use only)

State Association Code: _____

Current League Code: _____

Current Team Code: _____

CLAIM PROCEDURE:

- Participant (or legal guardian if under the age of 18) must complete this form in its entirety or it may be returned to you by the U.S.A.S.A. State Association.
- Do not delay submitting this claim form.** This form must be received, with or without attachments, within 90 days from the date of the accident, or benefits may be denied due to untimely filing.
- Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your U.S.A.S.A. State Association office for validating.
- Once the U.S.A.S.A. State Association has validated your claim, they will forward it to the insurance company for processing. The insurance company will inform you of any additional information they may need to process your claim.

- COMPLETE THIS FORM.**
- ATTACH ALL BILLS.**
- MAIL TO:**



U.S.A.S.A.
Special Risk
ACCIDENT CLAIM FORM
Please print or type.

IF PARTS A and B ARE NOT COMPLETED IN FULL, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

PART A – This section MUST be completed, dated and signed by the Injured Person – or by his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.

1. Name of Injured Person (Insured): <i>First /Middle/Last</i>	1a. Date of Accident: <i>Mo/Day/Year</i>
2. Complete Mailing Address: <i>Street/City/State/Zip</i>	
3. Area Code/Home Telephone #:	3a. Area Code/Work Phone #:
4. Social Security #:	5. Date of Birth: <i>Mo/Day/Year</i>
6. <input type="checkbox"/> Male <input type="checkbox"/> Female	6a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Full-time Student
7. Are you currently enrolled in any health insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.	
7a. If you are not enrolled in any health insurance plan, we require written verification from your employer and your spouse's employer (if applicable), or Bursar's office if you are a full-time college student.	
7b. Have you ever been treated for this or a similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, last date treated: _____	
7c. If you are self employed or unemployed and not covered under any health insurance plan, please sign below. Signature: _____	

PART B - This section MUST be completed, then signed by an official of your local organization.

1. Team Name:
2. League Name:
3. Injury Occurred at: <input type="checkbox"/> Event <input type="checkbox"/> Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game
3a. Name of Event:
3b. Injury occurred on: <input type="checkbox"/> Indoor Field <input type="checkbox"/> Outdoor Field
4. Describe how accident occurred:
5. Type of Injury:
6. Name and Phone Number of Coach, Manager or Referee present at the time of the accident:
7. Signature: _____ Title: _____



AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc. or its representatives to furnish to any hospital, physician or other person who has attended me, and my insurance carrier, any and all information with respect to the accidental injury for which I am claiming insurance benefits.

I waive any provision of law to the contrary and hereby authorize any hospital, physician or other person who has attended me, and my insurance carrier or employer, to furnish to K&K Insurance Group, Inc. or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, and copies of all hospital, medical or insurance records including, but not limited to, information regarding other insurance coverages. I agree that a photocopy of this authorization shall be considered as effective as the original.

(The above paragraphs are being used in order to facilitate our obtaining and providing proper information needed to quickly process your claim.)

Signature: _____ Date: _____

CLAIMS ADMINISTRATION BY K&K INSURANCE GROUP c/o YOUR STATE ASSOCIATION VERIFICATION OFFICER

S-18/LR-1 12/98

Arkansas, Florida, Kentucky, Michigan, New Jersey and Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or another 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, subject to criminal prosecution and civil penalties.

California

For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

California Insurance Frauds Prevention Act 1871.2

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 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.

Idaho

Any person who knowingly and with the intent to injure, 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.

Minnesota

A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

New Hampshire

Any person who, with 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 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 or 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

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. (360.S. 5361.1)

U.S. AMATEUR SOCCER ASSOCIATION ACCIDENT AND HEALTH PLAN

ADDITIONAL INFORMATION

The Accident and Health Plan under the U.S.A.S.A. policy provides a supplementary/excess combined maximum benefit not to exceed \$5,000 per incident after the incident deductible of \$400 has been satisfied. Only allowable charges may be applied to the deductible or paid in accordance with policy limits. Medical charges for injuries incurred only at the time of the covered accident are eligible. The injured participant must seek treatment for the claimed accident within 60 days of the injury. Services other than those with pre-established maximums are subject to plan guidelines. (This is a benefit description only, not a guarantee of payment.) A more detailed summary of benefits will be provided to the participant upon request.

Claim forms with incomplete information will require additional information requests that delay payment. Should you receive a request for additional information, please respond promptly.

QUESTIONS & ANSWERS

1. What is a Primary Carrier?

The Primary Carrier is the insurance company who will consider your medical expenses first and issue any eligible payments. A Primary Carrier is any Health Insurance Plan through your place of employment, a family plan through a relative's place of employment, a University health plan for college students, Retirement policy, or other accident policies and/or Medicare.

2. What is Excess or Supplementary coverage?

This is a coverage that will reduce your out of pocket expenses after your Primary Health Insurance has paid your eligible medical expenses.

3. What if I do not have any other Health Insurance?

Then, the U.S.A.S.A. plan will be considered the Primary Carrier. Keep in mind that if this is the case, it will not change policy limits, guidelines or procedures. You will be responsible for any difference between what the provider charged and what the insurance companies paid.

4. What is considered an itemized bill?

An itemized bill will have all the following: the complete name, address, phone number and tax identification number of the provider (doctor or hospital). It will also have a diagnosis code, five digit procedure codes, dates and services rendered and the amounts charged.

5. What is an Explanation of Benefits?

An Explanation of Benefits (commonly abbreviated EOB) is a statement your Health Insurance company sends to you whenever they process a claim. It will show the types of service, how much was allowed, how much was applied to a deductible and the amounts charged.

6. How is payment calculated?

We look at what the provider charged (before primary carrier calculations) and determine the maximum allowable based on our limits. Then, we check to see if you have satisfied your accident deductible. If the deductible has not been satisfied, we subtract the deductible amount from the allowed charges. If there is a balance left, we then look to see what the primary carrier paid. This is deducted as well. Any balance due, after the above calculations, is remitted to the participant or health care provider.

7. Do I have to fill out a claim form every time I submit bills?

No, additional forms are not needed once we have received your validated claim form. Additional medical bills and Explanation of Benefits can be sent directly to the insurance company for handling.

Foreword this claim form to: WVSA, PO Box 3360, Beckley, WV 25801

Please pay particular attention to the following items:

- 1. The insurance company must receive this form within 90 days of the accident.**
- 2. Submit this form immediately. Even if the documentation is not attached.**
- 3. Make sure you submit a copy of the USSF Referee Report with this form.**
- 4. Make sure all bills and payments by other insurance companies are sent to the WVSA office.**
- 5. Attach a copy of your Player Pass both front and back**
- 6. Part A is filled out by the injured person and part B is to be filled out by your registrar.**