Medical / Dental Accident
YOUTH CLAIM FORM

Deductible: $500 **Co-insurance: 80/ 20 52-week benefit eligibility period**

1. NAME: (first)_____(last) _____
2. ADDRESS: _____(city)_____(state)_____(zip)_____
3. TELEPHONE #: _____ 4. Contact EMAIL ADDRESS: _____
5. CLAIMANT IS A: ☐ Player ☐ Coach ☐ Official ☐ Other 6. GENDER: ☐ Male ☐ Female
7. BIRTHDATE: ____/____/____ 8. SS#: xxx-xx- _____

ACCIDENT INFORMATION (required)

1. ACCIDENT DATE: ____/____/____
2. BODY PART INJURED: _____
3. ACCIDENT OCCURRED DURING: ☐ Game ☐ Practice/Scrimmage ☐ Tournament ☐ Camp/Clinic ☐ Other
4. DESCRIBE HOW / WHERE ACCIDENT OCCURRED: _____

_____

5. FIELD / FACILITY NAME WHERE ACCIDENT OCCURRED: _____
6. LEAGUE NAME: _____
7. CLUB NAME: _____TEAM NAME: _____
8. PLAYER'S POSITION: _____
9. TYPE: ☐ Competitive ☐ Recreational
10. LOCATION: ☐ On field ☐ Indoor ☐ Spectator Area ☐ Other
11. SURFACE: ☐ Dirt ☐ Grass ☐ Outdoor Turf ☐ Indoor Turf
12. SURFACE CONDITION: ☐ Dry / Normal ☐ Icy ☐ Wet / Rainy ☐ Muddy
13. STATUS ☐ Hit By Object ☐ Collision with Opponent or with Teammate
☐ Other_____

CONTACT INFORMATION (required)

Relationship to Claimant: (choose one)

☐ Father ☐ Mother ☐ Guardian ☐ Self ☐ Spouse

NAME: _____

ADDRESS: _____(city)_____(state)_____(zip)_____

TELEPHONE: _____

CONTACT EMAIL: _____

☐ Employed ☐ Self-employed ☐ Unemployed

EMPLOYER INFORMATION: _____

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐ Yes ☐ No (Attach separate sheet, if necessary)

Insurance company information:

NAME: _____

ADDRESS: _____(city)_____(state)_____(zip)_____

TELEPHONE #: _____

AUTHORIZATION

AFFIDAVIT: I verify that the statement on the other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. mail may be fraudulent and violate federal laws, as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any health care provider, doctor, medical professional, medical facility, insurance company, person or organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____ _____

CLAIMANT SIGNATURE *(Parent or guardian, if participant is a minor)* DATE

SEND COMPLETED CLAIM FORM TO:

insurancequestions@usclubsoccer.org

Or by mail to:

US Club Soccer - *Claims Dept.*

716 8th Avenue North, Myrtle Beach, SC 29577

TO BE COMPLETED BYAUTHORIZED US CLUB SOCCER ADMIN OFFICE REPRESENTATIVE

POLICY HOLDER: US Club Soccer Policy #: US561695

☐ YES – Sponsored / Sanctioned Activity ☐ YES - Claimant was Active Member on Date of Accident

Authorized Signature: _____ Title Director Admin Office Date: _____

I certify that the foregoing information is true and correct.

Send completed Youth Claim Form to:
insurancequestions@usclubsoccer.org
Or by mail to:
US Club Soccer - Claims Dept.
716 8th Avenue North, Myrtle Beach, SC 29577

A Medical Claim form and an Insurance Claim Verification form must be submitted to US Club Soccer before the claim is forwarded to A-G Administrators, Sports Insurance Specialists for processing.

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 / 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. Once the $500 deductible has been satisfied, benefits are payable at 80% of the allowable rate. Additionally, some benefits may be subject to internal policy limits.

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 **52-week** benefit period from date of injury. Medical or dental expenses that are incurred within **52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52-week** benefit period will not be covered by this policy.

3. ***Please remember:***
   a) Once the Youth Claim Form has been authorized by US Club Soccer, you can advise your doctors / hospitals of this program. Once your primary insurance has processed the bill, the medical provider can then file claims directly with A-G Administrators , P.O. Box 979 Valley Forge, PA 19482. Phone 610-933-0800. Do not send bills, EOB's or statements to US Club Soccer.

   b) **Itemized bills are required:** You or your providers must submit itemized bills; balance due bills or notices. Forms needed are noted below. 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 -** 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 -** standard form used by hospitals to show medical treatments / charges made for services.
   - **Primary Insurance Explanation of Benefits** (if applicable).

4. **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.

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

California & Texas Residents: 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 Residents: 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.

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 Residents: 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.

New York Residents: 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.

Tennessee Residents: 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.

Virginia Residents: Any person who, with the 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 may have violated state law.