"IGNITING PASSION FOR THE GAME"®

Affiliated with the United States Youth and Amateur Soccer Associations,
United States Soccer Federation and Federation Internationale de Football Association

FILING AN ADULT INSURANCE CLAIM

You are required to submit the items listed below in order for your insurance claim form to be processed. If we receive your claim form without the required items, it will be returned until all items are submitted, which may result in unnecessary delays in processing your claim.

If the injury occurred during *sanctioned <u>outdoor</u>* play:

- Completed Claim Form
- A copy of the team official roster signed by the Member Association/League registrar
- A **separate written statement** from your coach, assistant coach, or team manager, if the injury occurred during a scheduled practice or game. Must be signed and dated.

If the injury occurred during *sanctioned <u>indoor</u>* play:

- Completed Claim Form
- A copy of the team roster signed by the affiliated indoor facility manager.
- A legible copy of the front and back of your indoor player I.D. card.
- A copy of the game sheet from the game in which the injury occurred. (If during game)
- A **separate written statement** from your coach, assistant coach, or team manager, if the injury occurred during a scheduled practice or game.

The items listed above are required to submit your claim to the insurance company, but if you have your itemized bills or Explanation of Benefits from your primary insurance, you may provide them at this time. They are not required for us to submit, but the insurance company will request them from you later.

Completed forms may be emailed to insurance@ntxsoccer.org

Questions – Please call 214-297-5022

Signature of State Association / Nationwide affiliate verification officer: ______________________ Date: ______________

CLAIM PROCEDURE: U.S.A.S.A. SPECIAL RISK ACCIDENT CLAIM FORM **Please print or type.**

1. 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/Nationwide affiliate.
2. **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. It must be completed in its entirety. Answer every section.
3. 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/Nationwide affiliate office for validating.
4. Once the U.S.A.S.A. State Association/Nationwide affiliate has validated your claim, they will **forward it to USASA National Office** to preview and forward to the insurance company. The insurance company will inform you of any additional information they may need to process your claim.

1. **COMPLETE THIS FORM.**
2. **ATTACH ALL BILLS.**
3. **MAIL TO: State Verification/Nationwide affiliate officer below**

U.S.A.S.A. SPECIAL RISK ACCIDENT CLAIM FORM

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): *First /Middle/Last*

1a. Date of Accident: *Mo/Day/Year*

2. Complete Mailing Address: *Street/City/State/Zip*

3. Area Code/Home Ph#:

3a. Area Code/Work Ph#:

3b. Email Address:

4. Is the injured person a Medicare/Medicaid beneficiary? ☐ Yes ☐ No

4a. If Yes, please provide Social Security number or Health I.D. number: ______________________

5. Date of Birth: *Mo/Day/Year*

6. ☐ Male ☐ Female

6a. ☐ Single ☐ Married ☐ Full-time Student

7. Are you currently enrolled in any health insurance and/or other soccer accident plan? ☐ Yes ☐ No
If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.

Company Name: ______________ Group Name: ______________ Policy Number: ______________

Company Name: ______________ Group Name: ______________ Policy Number: ______________

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. If you are self-employed or unemployed and not covered under any health insurance plan, please sign below.

Signature of Player: ______________________

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

1. Team name:

1a. League name:

2. State Association/Nationwide affiliate:

2a. Region:

3. Injury occurred at: ☐ Game ☐ Practice ☐ Travel ☐ Other Event

4. Name and type of event:

4a. Injury occurred on: ☐ Indoor Field ☐ Outdoor Field

5. Describe how accident occurred *(example: tackled from behind, tripped and fell, collision with player, etc.)*:

6. Type of injury *(example: broken arm, sprained ankle, broken nose, etc.)*:

6a. Body part injured *(example: ankle, knee, shoulder, head, etc.)*:

7. Name and Phone Number of coach, manager or referee present at the time of the accident:

8. *I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include prosecution.*

Signature of League Verification Officer:______________________________ Title:__________

Signature of USASA Verification Officer:______________________________ Title:__________

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize A-G Administrators 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 herby authorize any hospital, physician or other person who has attended me and my insurance carrier or employer to furnish to A-G Administrators or its representatives any an 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.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia and Washington: 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 and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefit and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include prosecution.

Signature of Player: ____________________ Date: ____________

Signature of Coach, Manager or Referee: ____________________ Date: ____________

AFTER you receive your acknowledgement letter, you may contact A-G Administrators at 800.634.8628 if you have any questions about your claim.

A-G Administrators, LLC: PO Box 979: Valley Forge, PA 19482
Email: Claims@agadm.com • Fax: 610.933.4122

Player Accident Insurance Coverages

USASA provides several options for state associations and leagues to decide on the appropriate coverage needs. Such as when a player might kick a ball wrong and injures leg or maybe a player slips and breaks a leg on field.

The options include the following: no accident coverage, $5,000.00, or $25,000.00 maximum in a schedule benefit plan with a $400.00 deductible. The plans are in place to fill gaps, holes, deductibles, co-pays and coinsurance on participant's health policy. This is a secondary coverage which means it pays after your health policy pays.

The accident insurance is intended to act as a secondary policy to a member's primary insurance. If no primary insurance exists this then your USASA plan becomes the primary policy.

With the skyrocketing expenses and expanding changes in health care with The Affordable Health Care Act or as most know it "Obama Care" the need for secondary insurance is almost a must. Most plans today have even more deductibles, co-pays and coinsurance conditions which make USASA's secondary coverage's even more attractive.

The combination of General Liability and Participant Accident Coverage, secure good fields and gives comprehensive protection to participants and entities. These protections give peace of mind to all participants and their families as it removes some of the risk of playing a contact sport.

Participant Accident Insurance:

Below is intended as a general description of excess plan benefits available under the Participant Accident Policy.

INSURED PERSON means each person who qualifies as a "Member of a Team" during the Team's Sport Coverage Period.

COVERED ACTIVITIES: This policy covers injury resulting from accident which occurs during the Sport Coverage Period for the Insured Person's Team while he or she is (a) participating as a Member of a Team in a scheduled game, an official tournament game, or in a practice session of the Team; or (b) traveling directly to or from a game or practice sessions as a Member of a Team.

ACCIDENT PLAN LIMITATIONS AND EXCLUSIONS

Accident Medical Expense Benefit $5,000 maximum benefit

Deductible Amount $400 of all eligible expenses

-Optional $25,000 plan

$1,000 maximum dental limit (sound, natural teeth only)

Accidental Death Benefit $5,000 principal sum

Accidental Dismemberment Benefit $5,000 principal sum

Hospital Room & Board Expense (In-Patient) $300 maximum per day

Hospital Miscellaneous (In-Patient) $1,000 maximum per admission

Hospital Miscellaneous Expense (Out-Patient) $250 per admission

Hospital Emergency Care $350 maximum per injury

Physician Expense (Non-surgical) $35 maximum per visit limit, 10 visits per injury

Surgeon Expense (In-or-Out-Patient) Allowed at 50% of Usual, Reasonable & Customary (UCR) amount

Assistant Surgeon Expense Allowed at 25% of surgeon's UCR

Anesthesiologist Allowed at 25% of surgeon's UCR

Physical Therapy or Chiropractic Expense $25 maximum per visit, limit 15 visits per injury

X-rays, Imaging, MRI or Cat Scans (Out-Patient) $150 maximum per injury

Ambulance Expense $150 maximum per injury

Orthopedic appliances or braces as a result of covered injury NOT for the prevention of injury $400 maximum per injury

EXCLUSIONS

1. Intentionally self-inflicted injury, suicide, or attempted suicide, whether sane or insane;

2. War or act of war, whether declared or undeclared;

3. Injury sustained while in the armed forces (land, water or air) of any country or international authority;

4. Injury sustained while in or on, boarding or alighting from, being struck or run down by , any aircraft except as an airline passenger on an aircraft: (a) operated by a passenger airline on a regularly scheduled trip over its established route or that is chartered by that airline; or (b) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States or any national government recognized by the United States:

5. Medical services performed by any person retained or employed by the Team or Policyholder;

6. Repair, replacement, examination for prescriptions, or fitting of: (a) eyeglasses; (b) contact lenses; or (c) hearing aids;

7. Dental work or treatment on natural teeth which is not necessary for the repair or relief of injury;

8. Cosmetic or plastic surgery which is not necessary for the repair or relief of injury;

9. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration;

10. Repair or replacement of artificial limbs or orthopedic braces;

11. Injury sustained while the Insured Person is voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless the drug is taken as prescribed or administered by a licensed Physician;

12. Injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;

13. Injury sustained as a result of the Insured Person's being legally intoxicated from the use of alcohol while operating a motor vehicle;

14. Expenses incurred for services, treatment, supplies or facilities rendered by: (a) the Policyholder's health service or infirmary; or (b) any Physician or nurse employed or retained by the Policy holder;

15. Hernia;

16. Expenses covered under any automobile reparations insurance (no-fault) or automobile insurance medical payments benefit.

SPECIAL NOTICE: This is only a very general reference to what coverage(s) the insurance policy or policies provide and is not intended to attempt to describe all of the various details pertaining to the insurance policy. Actual coverage's are detailed in the policy and are always subject to all terms, provisions, conditions, and exclusions as contained therein. You should not rely upon this general summary, but should consult the actual policy language for a complete description and details regarding coverage.