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 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)

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.

5. **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 information contact:
NAHGA Claims Services
PO Box 189
Bridgton, Maine 04009-0189
Phone: 800.952.4320
Fax: 207.647.4569

Send this claim form for authorization to:
New Jersey Youth Soccer Association
569 Abbington Drive Suite 5
East Windsor, NJ 08520
Phone: 609-490-0725
Fax: 609-490-0731

COMPLETE AND SEND THIS FORM TO:

New Jersey Youth Soccer Association
569 Abbington Drive, Suite 5
East Windsor, NJ 08520

MEDICAL/DENTAL ACCIDENT CLAIM FORM

New Jersey Youth Soccer

$1,000.00 Deductible **104 week eligibility period**

Please read instructions on Page 3 before completing this form
SECTION I - TO BE COMPLETED BY CLAIMANT PARENT OR GUARDIAN - Required

1. **NAME:** (first) _____ (last)_____
2. **ADDRESS**: _____ (city) _____ (state) _____ (zip code)_____
3. **TELEPHONE:** _____ **BIRTHDATE:** ___/___/___ **GENDER:** ☐ Male ☐ Female
4. **CLAIMANT IS A:** ☐ Player **Include a copy of the Player's Pass with this claim** ☐ Coach ☐ Official ☐ Other
5. **ACCIDENT DATE:** _____/_____/_____ **ACCIDENT TIME:** _____ ☐ am ☐ pm
6. **BODY PART INJURED:**_____
7. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic
8. **IF ACCIDENT OCCURRED AT A TOURNAMENT, NAME OF TOURNAMENT**: _____
9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____

_____

10. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**_____

SECTION II - STATISTICAL INFORMATION - Required

NAME OF CLAIMANTS LEAGUE/CLUB/TEAM:_____

NAME OF OPPONENT ☐If during game or tournament) _____

TYPE OF TEAM:	☐ COMPETITIVE	☐ RECREATIONAL		
LOCATION:	☐ ON FIELD	☐ SIDELINES	☐ SPECTATOR AREA	☐ OTHER
SURFACE:	☐ DIRT	☐ GRASS	☐ OUTDOOR TURF	☐ INDOOR TURF
SURFACE CONDITION:	☐ DRY/NORMAL	☐ WET/RAINY	☐ ICY	☐ MUDDY
POSITION:	_____			
STATUS:	☐ HIT BY OBJECT	☐ COLLISION W/OPPONENT	☐ COLLISION W/TEAMMATE	
	☐ OTHER_____			

Coach/Club Verification Signature: _____

SECTION III - To Be Completed By New Jersey Youth Soccer - Only

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER
September 1, 2013	**September 1, 2014**	**SRG9131706**	**New Jersey Youth Soccer Association**

ADDRESS OF POLICYHOLDER			TELEPHONE NUMBER
569 Abbington Drive, Suite 5	**East Windsor, NJ**	**08520**	**609-490-0725**

Verify that the accident occurred during an activity sponsored or sanctioned by New Jersey Youth Soccer and whether claimant was a member at the time of the accident

☐ YES-Sponsored/Sanctioned Activity ☐ YES-Claimant Was Active Member On Date Of Accident

I certify that the foregoing information is true and correct.

SECTION IV STATEMENT OF OTHER INSURANCE

Claimant (if Adult) or Father/Guardian(Required)

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____ ZIP:_____

PHONE:_____

EMPLOYER:_____

PHONE:_____

☐ SELF EMPLOYED ☐ UNEMPLOYED

Claimant (if Adult) or Mother/Guardian (Required)

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____ ZIP:_____

PHONE:_____

EMPLOYER:_____

PHONE:_____

☐ SELF EMPLOYED ☐ UNEMPLOYED

If you are employed but have no insurance, you must include a letter of verification from your employer on their letterhead that no insurance is provided to you (or to your dependents, if this claim is for your child) through your workplace.

IS CLAIMANT a member of another youth soccer organization? ☐ YES ☐ NO Name: _____
IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? ☐ YES ☐ NO
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? ☐ YES ☐ NO

INSURED NAME: _____ ID#: _____ INSURED GROUP# /NAME:_____

COMPANY NAME:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

PHONE:_____

****Please include a copy of insurance card (both sides)**

Note: IF CLAIMANT IS A MINOR AND HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM EITHER PARENT'S PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY:

_____

SECTION V AUTHORIZATION REGARDING PAYMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize the Insurance Company or their representatives to pay benefits in connection with this accident or injury directly to the doctor, hospital or other provider of service. If paid receipts are submitted with this claim form, benefits will be paid to the insured.

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 CLAIMANT/PARENT (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 CLAIMANT/PARENT (required): _____ **DATE:**_____

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.