SPORTS INSURANCE SPECIALISTS

State Association

SPECIAL RISK
ACCIDENT CLAIM FORM

Please complete claim form and submit to NJYS

For questions, however, please contact
A-G Administrators: customerservice@agadm.com.

IMPORTANT: This claim form must be mailed or emailed to your state association below:
New Jersey Youth Soccer Association, 3 Paragon Way, Suite 400, Freehold, NY 07728,
Insurance@NJYouthSoccer.com

YOUR INFORMATION

First Name:_____ Last Name:_____

Title:_____ School/Organization Name:_____

Email Address:_____ Phone Number:_____

POLICYHOLDER INFORMATION

Policyholder: **New Jersey Youth Soccer Association (Policy #: US2066611)**

Address: **3 Paragon Way, Suite 400** (STREET) **Freehold** (CITY) **NY 07728, USA** (STATE, ZIP)

PARTICIPANT INFORMATION

Participant's Name:_____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

Date of Birth:_____ Sex: ☐ M ☐ F **Social Security #:**_____

Participant's Phone Number (or Parent's if minor): _____

Participant's EMAIL (or Parent's if minor): _____

Participant's Home Address: _____
(STREET) (CITY) (STATE, ZIP)

STATISTICAL INFORMATION

Name of Local association or league:_____

Name of Club (if applicable):_____ Name of team: _____

Age Division (U-12, U-10, etc):_____ ☐ Competitive ☐ Recreational

Time:	☐ Morning	☐ Afternoon	☐ Evening	☐ After Hours
Location:	☐ On Field	☐ Sidelines	☐ Spectator Area	☐ Other
Disposition:	☐ On-site Care Only	☐ Ambulance	☐ Personal Transpiration	☐ Refused Care
Location:	☐ On Field	☐ Sidelines	☐ Spectator Area	☐ Other
Surface:	☐ Dirt	☐ Grass	☐ Artificial Turf	☐ Other
Surface Condition:	☐ Dry	☐ Wet	☐ Icy	☐ Irregular
Position:	☐ Goalie	☐ Forward	☐ Defender	☐ Other
Activity:	☐ Running w/ ball	☐ Running w/o ball	☐ Defending	☐ Other
Situation:	☐ Hit by ball	☐ Collision w/ Participant	☐ Non-Contact Injury	☐ Other

A-G ADMINISTRATORS LLC
SPORTS INSURANCE SPECIALISTS
PO Box 21013, Eagan, MN 55121
Ph: **(610) 933-0800** **Fx: (610) 933-4122** *Email:* **claims@agadm.com**

ACCIDENT INFORMATION

Circumstance: ☐ Game ☐ Practice ☐ Conditioning ☐ Other (Please explain in Nature of Injury section.)

Activity/Sport (if athletic related):_____ Accident Date:_____

Body Part Injured:_____ Place of Accident:_____

Nature of Injury (Details of what happened.):_____

_____

_____

INSURANCE INFORMATION

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

Insurance Company Name:_____

Insurance Company Address:_____
STREET CITY STATE, ZIP

Policy Number: _____ ID#:_____

Is the participant eligible for Medicaid or TriCare Benefits? ___ YES ___NO
If yes, please file for benefits under the Participant Accident Plan before submitting expenses to Medicaid or TriCare.

AUTHORIZATION

AFFIDAVIT: I verify that the statement on 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.

WARNING: 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.

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

COACH SIGNATURE **DATE**

ORGANIZATION/POLICYHOLDER SIGNATURE **TITLE** **DATE**

* itemized medical bills AND primary insurance explanation of benefits shouls be sent to AG Administrators

After claim has been secured send additional documents and bills using our secure upload portal: upload.agadministrators.com Alternatively, submit documents to claims@agadm.com.

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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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