



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** **Freehold** **NY 07728, USA**
STREET CITY 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 Transportation 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

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

The below signature to be completed by the NJYS State Office. Email form for approval to insurance@njyouthsoccer.com

DATE

ORGANIZATION/POLICYHOLDER SIGNATURE

TITLE

DATE

* itemized medical bills AND primary insurance explanation of benefits should 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.