

COMPLETE AND RETURN THIS FORM TO:



P.O. Box 390 Short Hills, NJ 07078



\$100.00 Deductible

104 week eligibility period

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN (Required)

1. **NAME:** (first) _____ (last) _____
2. **ADDRESS:** _____ (city) _____ (state) _____ (zip code) _____
3. **BIRTHDATE:** ___/___/___ **SEX:** Male Female
4. **CLAIMANT IS A:** Player Coach Official Other
5. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ am pm
6. **BODY PART INJURED:** _____
7. **ACCIDENT OCCURRED DURING:** Game Practice Tournament Camp/Clinic Other _____
8. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:** _____

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

SECTION II STATISTICAL INFORMATION (Required)

1. **NAME OF TEAM/CLUB:** _____
2. **TYPE:** COMPETITIVE RECREATIONAL
3. **LOCATION:** ON FIELD SIDELINES SPECTATOR AREA OTHER
4. **SURFACE:** DIRT GRASS OUTDOOR TURF INDOOR TURF
5. **SURFACE CONDITION:** DRY/NORMAL WET/RAINY ICY MUDDY
6. **POSITION:** GOALIE FORWARD DEFENDER OTHER _____
7. **ACTIVITY:** RUNNING W/BALL RUNNING W/OUT BALL DEFENDING OTHER _____
8. **STATUS:** HIT BY BALL COLLISION COLLISION W/OBJECT OTHER
 W/PLAYER

SECTION III TO BE COMPLETED BY AUTHORIZED OFFICIAL (Required)

POLICY EFFECTIVE DATE September 1, 2006	POLICY EXPIRATION DATE September 1, 2007	POLICY # PST2461C	NAME OF POLICYHOLDER New Jersey Youth Soccer Association
ADDRESS OF POLICYHOLDER (Street) P.O. Box 848	(City) Hightstown	(State) NJ 08520	TELEPHONE NUMBER 609-490-0725
VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT. YES-SPONSORED/SANCTIONED ACTIVITY YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT			
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.			
AUTHORIZED SIGNATURE:		TITLE:	DATE:

SECTION IV STATEMENT OF OTHER INSURANCE (Required)

Father/Guardian/Claimant

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
EMPLOYER: _____
PHONE: _____
SELF EMPLOYED UNEMPLOYED

Mother/Guardian/Claimant

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
EMPLOYER: _____
PHONE: _____
SELF EMPLOYED UNEMPLOYED

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NO

INSURED NAME: _____ ID#: _____ INSURED GRP#/NAME: _____
COMPANY NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: _____

SECTION V ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

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 PARENT/GUARDIAN/CLAIMANT (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 PARENT/GUARDIAN/CLAIMANT (Required): _____ DATE: _____

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED:

1. Accident medical expense coverage under this policy is provided 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.
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.
104-weeks: This policy is subject to a **104-week** eligibility 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) An Official or Administrator of the Policyholder must complete their section of the claim form.
 - b) Please make sure you have completed the entire claim form and signed where required.
 - c) Please attach all itemized bills to this form. Subsequent bills can be sent in as you receive them with no additional claim forms.
Each bill must show the following:
 1. Provider's Name, address and phone number
 2. Provider's Federal Tax ID#
 3. Dates of service
 4. Diagnosis Description or Codes (ICD-9)
 5. Procedure Description of Codes (CPT)
 6. Charge for each procedure
 - d) Please attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Bollinger Insurance.
5. **Flexible Spending Account:** You must submit your bills through your primary insurance carrier and Bollinger Insurance first before accessing your Flexible Spending Account within your company.

For further information contact:

Bollinger, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
www.BollingerInsurance.com
www.BollingerSoccer.com

Send this claim form for authorization to:

New Jersey Youth Soccer Association
569 Abbington Dr, Suite 5
East Windsor, NJ 08520
Phone: 609-490-0725
Fax: 609-490-0731

Bollinger
Insurance Since 1876