



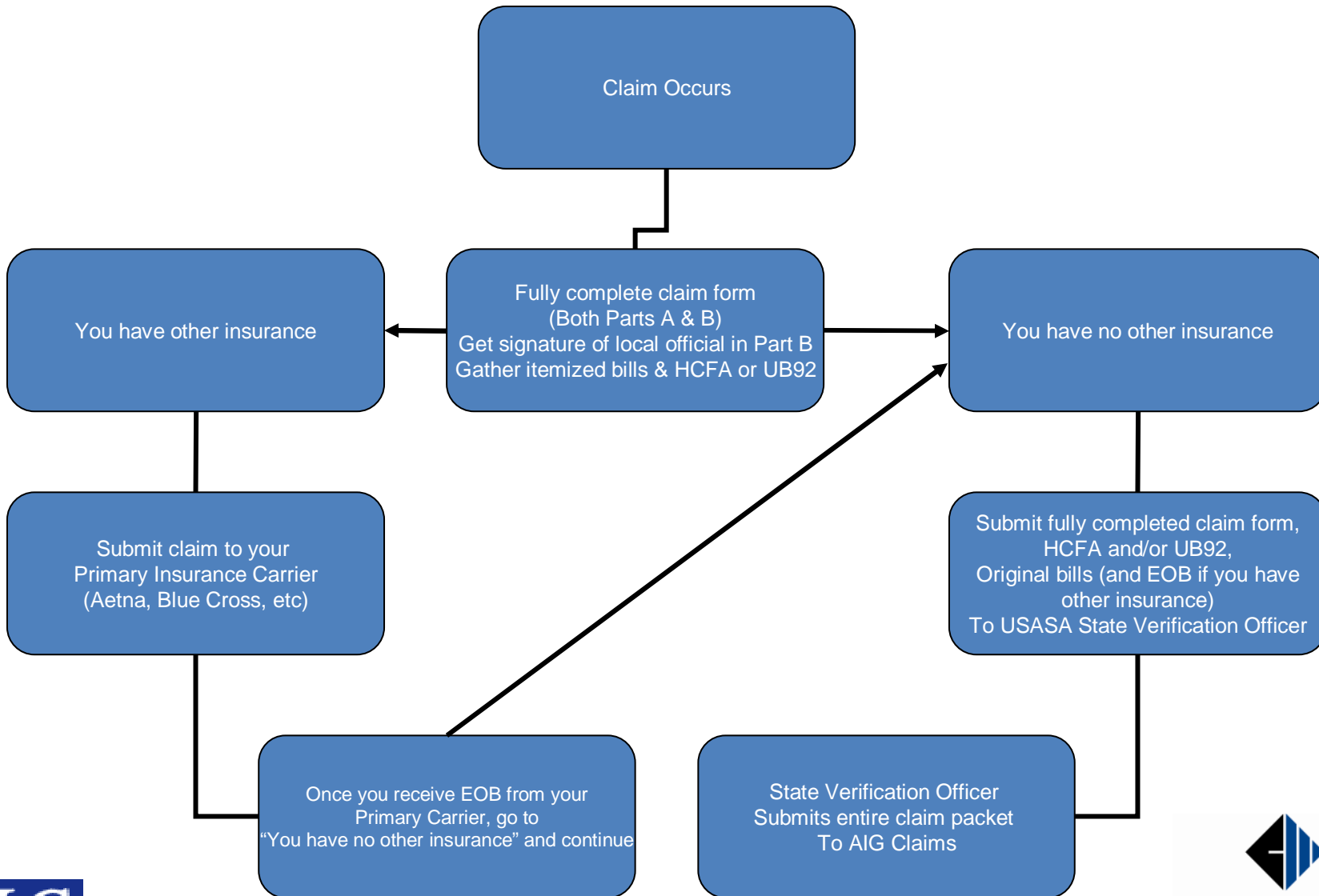
CLAIMS FILING INSTRUCTIONS FOR USASA ACCIDENT POLICIES

Effective 9/1/2008





Claim Filing Process Overview





Step By Step Instructions





1) You have been provided with a claim form that is designed specifically for USASA. Please use only this form. Do not delay submitting this form: it 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.

Signature of Claimant/Officer _____ Date _____

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

- Participant (or legal guardian if under the age of 18) must complete the form on its entirety or it may be returned to you by the U.S.A.S.A. S.A. Association.
- 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 later to be denied due to untimely filing.
- Once the claim form is completed, attach any relevant bills with corresponding primary care physician or hospital to you have received to date. This completed form must then be sent to your U.S.A.S.A. S.A. Association office for validation.
- Once the U.S.A.S.A. S.A. Association has validated your claim, they will forward it to the insurance company for processing. 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. SEE TO:

National Union Fire Insurance Co. of Philadelphia, Pa.  

PART A - This section MUST be completed, signed by the injured Person - or by their Parent or Guardian if the injured Person is under the age of 18 or blind or dependent.

1. Name of Injured Person (Last, First, Middle Initial)		2. Date of Accident (Month/Year)	
3. Complete Mailing Address (Street, City, State, Zip)			
4. Area Code/Phone No.		5. Area Code/Work Phone	
6. Social Security #		7. Date of Birth (Month/Year)	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed Student	

8. Are you currently enrolled in any health insurance and/or 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 Director'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 then signed by an official of your local organization.

2. Designation: _____

3. State: _____	3. Zip: _____
4. Injury occurred on <input type="checkbox"/> Even <input type="checkbox"/> Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game	
5. Reason: _____	
4b. Injury occurred on <input type="checkbox"/> Indoor Field <input type="checkbox"/> Outdoor Field	
6. Location (Neighborhood/City): _____	
6. Type of Injury: _____	
7. Name and Phone Number of coach, manager or referee present at location of the accident: _____	
8. Signature of Official: _____	Date: _____

AUTHORIZATION

I warrant any provision of law to the contrary and hereby authorize The National Union Fire Insurance Company of PA, or its representative 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 warrant any provision of law to the contrary and hereby authorize any hospital, physician or other person who has attended me and my insurance carrier, or employer to furnish to The National Union Fire Insurance Company of PA, or its representative any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatment, and copies of all medical, medical or insurance records available, but not limited to, information regarding other insurance coverage. I agree that a photocopy of this authorization shall be considered as effective as the original.

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.

Penalties of New York: Any person who knowingly and with intent to defraud, any insurance company or other person files an application for insurance containing any materially false information, or consents for the payment of misleading information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle in a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and which also is subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or total claim for each violation.

Penalties of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or consents for the payment of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Penalties of New Jersey or California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly or consents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(This above paragraph is being used in order to facilitate our obtaining and providing proper information needed to quickly process your claim.)

Signature of Player: _____ Date: _____





Step By Step Instructions

(Continued)



2) Part A must be fully completed and signed by the participant or his/her legal guardian.

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): <i>First/Middle/Last</i>	1a. Date of Accident: <i>Mo/Day/Year</i>
2. Complete Mailing Address: <i>Street/City/State/Zip</i>	
3. Area Code/Home Ph#:	3a. Area Code/Work Ph#:
4. Social Security #:	5. Date of Birth: <i>Mo/Day/Year</i>
6. <input type="checkbox"/> Male <input type="checkbox"/> Female	6a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Full-time Student
7. Are you currently enrolled in any health insurance and/or soccer accident plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	





Step By Step Instructions

(Continued)



3) Part B must be fully completed, signed and dated by a local team/USASA organization official.

PART B - This section MUST be completed then signed by an official of your local organization.	
1. Team name:	
2. League name:	
3. State:	3. a. Region:
4. Injury occurred at: Event Practice Travel Game	
4.a. Name of event:	
4.b. Injury occurred on: Indoor Field Outdoor Field	
5. Describe how accident occurred:	
6. Type of injury:	
7. Name and Phone Number of coach, manager or referee present at the time of the accident:	
8. Signature of local official:	Title:





Step By Step Instructions

(Continued)



ABC Hospital & Clinic	
Patient: John Valdez	Date: 05/06/03
Condition: Leg Injured Playing Soccer	
05/06/03 54555 MED HISTORY & PHYSICAL EXAM	83.00
05/06/03 77767 XRAY LEG PA AND LAT	91.00
05/07/03 32333 CBC WITH 5-PART WBC	35.50
05/07/03 44434 PROTEIN TOTAL, SERUM	24.00
Total Charges	233.50

4) **Submit** itemized insurance billing forms.* These forms are available from your health care provider and include the patient's name, condition (diagnosis), type of treatment and date the expense(s) was/were incurred.

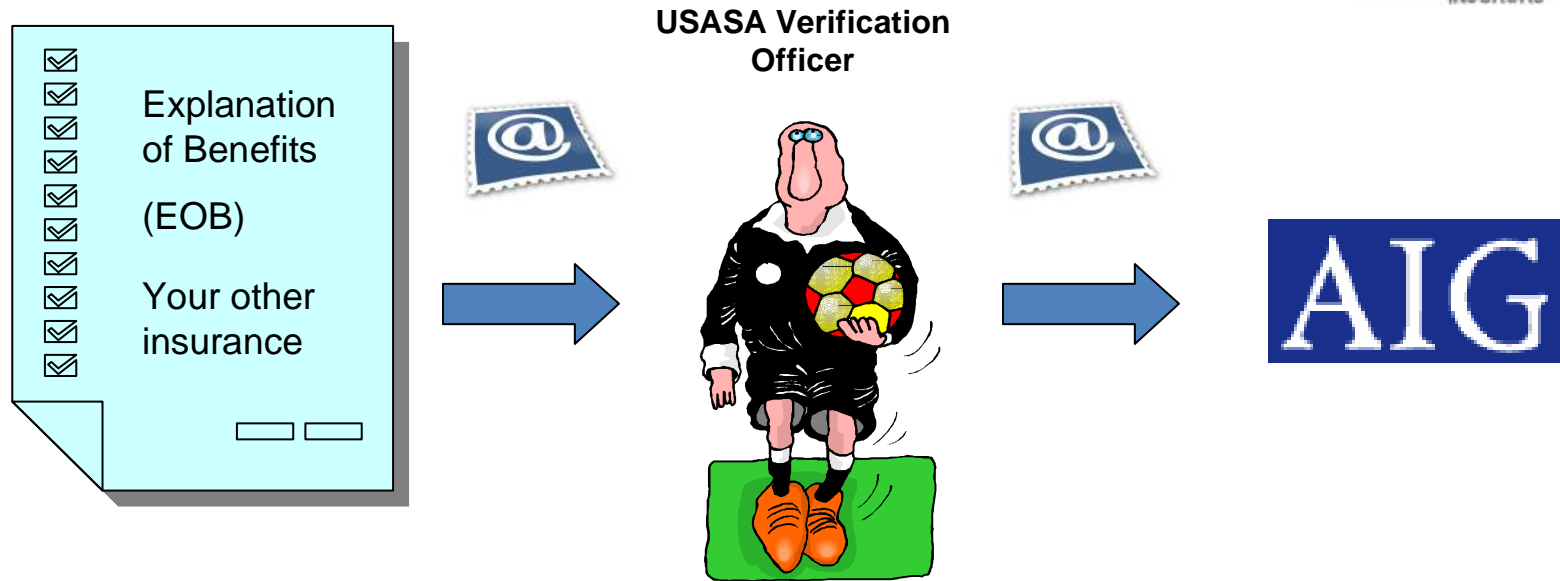
“Balance due” statements are not acceptable.

**HCFA 1500 form for physicians, UB92 form for facilities (i.e, hospitals).*





Step By Step Instructions (Continued)



- 5) If you have medical coverage under another policy you must submit the bills to your primary insurer first and submit a copy of your primary insurer's Explanation of Benefits (EOB) statement along with the claim form to your State Verification Officer.





Step By Step Instructions

(Continued)



6) Your state verification officer will then sign and mail the FULLY COMPLETED claim form to AIG. Upon receipt AIG will send an acknowledgement letter to the claimant and the State Verification Officer.





ANY QUESTIONS?



For questions, inquiries and/or status of your claim, call Angelica Cruz-Forero at (678) 240-1983.

