

## NEW YORK STATE WEST YOUTH SOCCER ASSOCIATION ACCIDENT MEDICAL CLAIM FORM

### GUIDELINES FOR SUBMITTING A YOUTH SOCCER ACCIDENT CLAIM FORM

1. Complete **ALL** questions on the Youth Soccer Accident Claim Form.
2. Have the coach or another local official that witnessed the accident sign **Section III** (COACH OR LOCAL OFFICIAL VERIFICATION).
3. Sign the claim form in **Section VI** (STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION.)
4. File this new report of claim within 30 days of the date of accident or as soon thereafter as is reasonably possible.
5. If you have other insurance, submit your itemized bills to the other carrier first. You will receive a payment Explanation of Benefit worksheet (EOB) from your other carrier. Do **NOT** wait until your other carrier has processed all your bills before filing a Youth Soccer Accident Claim Form.
6. You may attach itemized bills and your other carrier's EOBs that are ready at the time of submitting this Claim Form.
7. Send the Claim Form to your State Association for verification and authorized state signature. **DO NOT SEND THE CLAIM FORM DIRECTLY TO PULLEN INSURANCE SERVICES.**
8. Upon receipt of the claim form from your state association we will forward an acknowledgement form advising you of receipt of your claim. All future correspondence concerning your claim should be directed to K&K Insurance, who is the claims payor for American International Life Insurance Company of New York, at the address and phone number listed on your acknowledgement.

### HELPFUL REMINDERS

1. There is a \$100 deductible per covered accident for the 9/1/09 - 9/1/10 policy year.
2. Each itemized bill **MUST** show the following:
  - Provider of Service's Name
  - Provider's Address
  - Provider's Federal Tax ID#
  - Provider's Telephone #
  - Date of Service
  - Diagnosis Description or Codes (ICD-9)
  - Procedure Description or Codes (CPT)
  - Charge for each Procedure
3. Additional bills to be submitted at a later date (after the initial submission of your claim) should be mailed directly to K&K Insurance with the following information: Name of the claimant, date of the accident, and name of the State Youth Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond promptly to any correspondence requesting additional information. It is the Parent / Guardian / Claimant's responsibility to request this information from the provider of service or from your primary carrier.
6. An Explanation of Benefits will be sent to you by K&K Insurance on behalf of American International Life Insurance Company of New York.

### MOST FREQUENTLY ASKED QUESTIONS

#### What is an itemized bill?

An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

#### What if I don't have an itemized bill?

The Parent/Guardian must request this information from the provider of service. Some providers only mail a balance due statement. The claims payor, K&K Insurance, is unable to process this charge without an itemized bill. Again, request this information from the provider service. Explain that you have Youth Soccer Excess Accident Coverage.

#### Can you process this claim with my other insurance carrier's worksheet alone?

No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

#### What if I don't have my other carrier's payment explanation (EOB)?

The Parent/Guardian must request the EOB from their other insurance carrier.



POLICY NUMBER: SRG 0008069065

POLICY YEAR: 9/1/09 – 9/1/10

**IMPORTANT**  
This claim form must be mailed to your state association listed below:  
**New York State West Youth Soccer Association**  
41 Riverside Drive  
Corning, New York 14830

**SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

- Name: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_
- Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Sex:  Male  Female
- Home Address: (STREET) \_\_\_\_\_  
(CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP CODE) \_\_\_\_\_
- Type of claimant:  Player  Coach/Asst Coach  Other: \_\_\_\_\_
- Accident date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Description of injury (Indicate LEFT or RIGHT; i.e. Left Leg): \_\_\_\_\_
- Did accident occur during (✓ all that apply)  game  practice  tournament  indoor soccer  
 sanctioned/sponsored activities  travel directly and interruptedly to or from activity premises
- Describe how and where accident occurred: \_\_\_\_\_
- Name of field / facility where accident occurred: \_\_\_\_\_

**SECTION II 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
- Surface:  Dirt  Grass  Artificial Turf  Other (please list)
- Surface condition:  Dry  Wet  Icy  Irregular
- Position:  Goalie  Forward  Defender  Other (please list)
- Activity:  Running w/ ball  Running w/o ball  Defending  Other (please list)
- Situation:  Hit by ball  Collision w/ Participant  Non-contact injury  Other (please list)

**SECTION III COACH OR LOCAL OFFICIAL VERIFICATION**

\_\_\_\_\_  
Signature of Coach or Local Official      Coach or Local Official Name (print)      Date

**SECTION IV AUTHORIZED STATE OFFICIAL \***

I, \_\_\_\_\_, of the \_\_\_\_\_ certify that the above claimant was a registered player, coach, assistant coach, or participant at the time the accident occurred.

\_\_\_\_\_  
Signature of Authorized State Official      Title      Date

\* Must be signed by the authorized state soccer association administrator with the state soccer office.



2560 RIVER PARK PLAZA, SUITE 300  
FORT WORTH, TEXAS 76116  
(866) 738-6100 FAX (817) 738-2993  
PULLENINS.COM

CLAIMANT'S NAME: \_\_\_\_\_

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

**SECTION V PARENT / GUARDIAN / CLAIMANT INFORMATION**

Father / Guardian / Claimant

Mother / Guardian / Claimant

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Is claimant covered under ANY other insurance policy?  Yes  No

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured ID #: \_\_\_\_\_ Insured Group # / Name: \_\_\_\_\_

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 VI STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION**

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 substantial civil penalty where and to the extent allowed by state law.

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 National Fire Insurance Company or its representative, 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

\_\_\_\_\_  
Date

**SECTION VII ASSIGNMENT OF BENEFITS**

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

Coverage Underwritten by  
**American International Life Insurance Company of New York**