

Pullen Insurance Services, Inc.

6300 Ridglea Place, Suite 614
Fort Worth, Texas 76116
(817) 738-6100 ● Fax: (817) 738-2993

(NOTE: Claim Form must be fully completed and signed.)

Basic Procedures 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 Claim Form to your State Association for verification and signature.**
8. Upon receipt of the claim form from your state association we will forward an acknowledgement form advising you of the adjuster who will be processing your claim. All future correspondence concerning your claim should be directed to your assigned adjuster at the address and phone number listed on your acknowledgement.
9. See back page for **Frequently Asked Questions.**

Pennsylvania West State Soccer Association
855 Macbeth Dr #2
Monroeville PA 15146

Coverage Underwritten by
Hartford Life & Accident

Pullen Insurance Services, Inc.

6300 Ridglea Place, Suite 614
Fort Worth, Texas 76116
(817) 738-6100
Facsimile (817) 738-2993

POLICY #: 36-SB-205576

IMPORTANT

THIS CLAIM FORM MUST BE MAILED TO YOUR STATE ASSOCIATION LISTED BELOW:

Pennsylvania West State Soccer Association
855 Macbeth Dr #2
Monroeville PA 15146

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

- 1. NAME:(last) (first) (int.)
2. SOCIAL SECURITY NUMBER: 3. BIRTHDATE: 4. SEX: male female
5. HOME ADDRESS: (street) (city) (state) (zip code)
6. TYPE OF CLAIMANT: Player Coach/Asst.Coach Other 7. ACCIDENT DATE:
8. DESCRIPTION OF INJURY (Indicate LEFT or RIGHT; i.e. Left Leg):
9. DID ACCIDENT OCCUR DURING: (all that apply) game practice tournament indoor soccer sanctioned/sponsored activities travel directly and uninterruptedly to or from activity premises
10. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:
11. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:

SECTION II STATISTICAL INFORMATION

- 1. NAME OF LOCAL ASSOCIATION OR LEAGUE:
2. NAME OF CLUB (if applicable): 3. NAME OF TEAM:
4. AGE DIVISION: (U-12, U-10, etc.): 5. COMPETITIVE: RECREATIONAL:

Table with 5 columns and 13 rows detailing accident statistics: 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), 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).

SECTION III COACH OR LOCAL OFFICIAL VERIFICATION

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

SECTION IV **** TO BE COMPLETED BY AUTHORIZED STATE OFFICIAL ****

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

Signature of Authorized State Official Title Date

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: _____

S.S.#: _____

S.S.#: _____

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 subjects such person to criminal and civil penalties.

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 Hartford Life & Accident 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.

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THINGS TO REMEMBER

1. **EACH STATE HAS A DEDUCTIBLE.** Check with your State Association to find out the amount of your deductible.
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 your assigned adjuster at K&K, who is the claims payor for Hartford Life & Accident, 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 Hartford Life & Accident.

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 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.