



DES CHAMPS & GREGORY, INC.
INSURORS



CLAIMS FILING INSTRUCTIONS FOR USASA ACCIDENT POLICIES

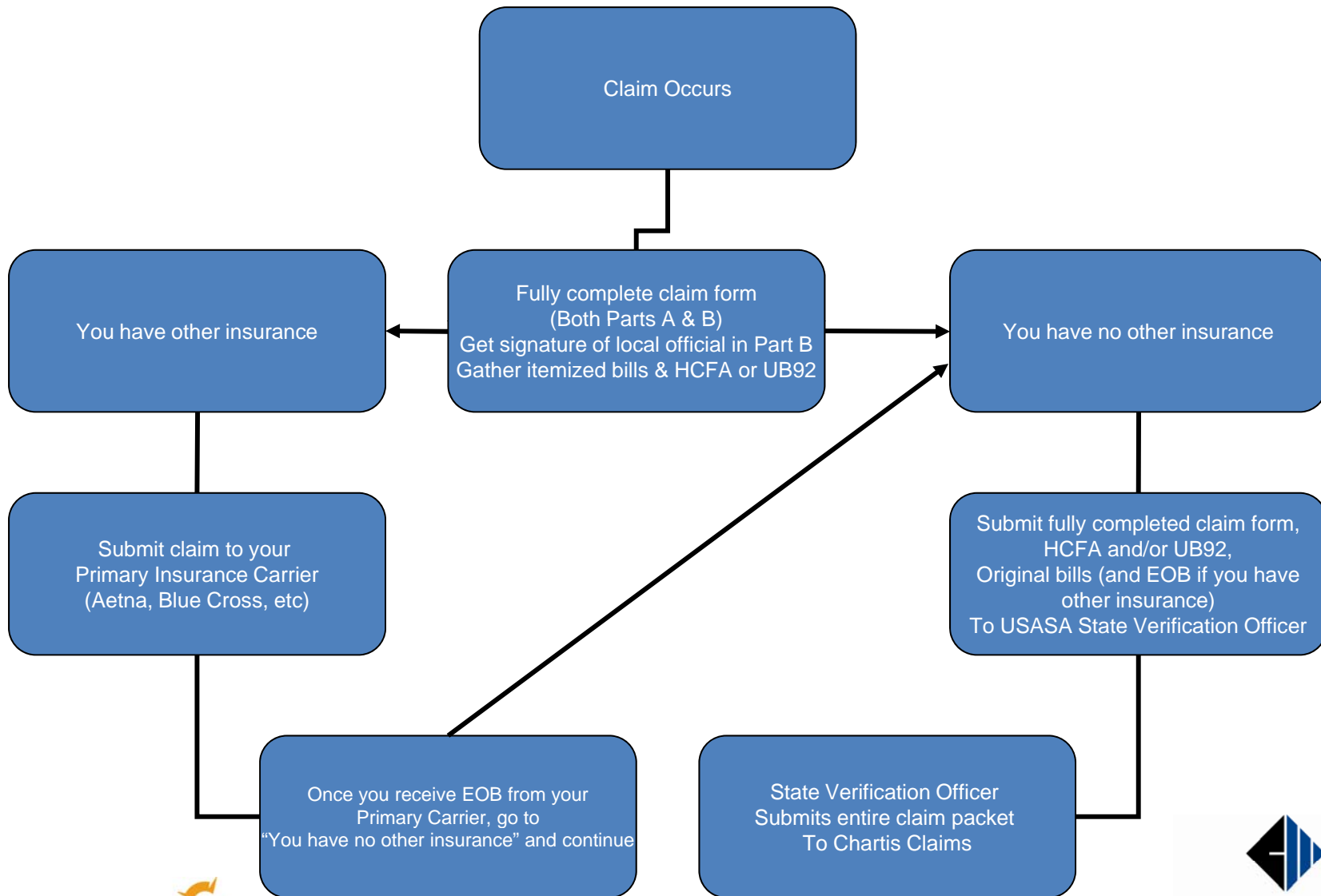
Effective 10/1/2009



COLEMONT®
INSURANCE BROKERS



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 Claim verification 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 this form in its entirety or it may be returned to you by the U.S.A.S.A. State 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 benefit may be denied due to untimely filing.
- Once the claim form is completed, attach any items to file with corresponding primary care or explanation of benefit if you have received to date. This completed form must then be sent to your U.S.A.S.A. State Association office for validation.
- Once the U.S.A.S.A. State 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: National Union Fire Insurance Co. of Pittsburgh, Pa.
 2. ATTACH ALL BILLS:  
 3. MAIL TO: _____

IF PARTS A and B ARE NOT COMPLETED IN FULL, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED

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

1. Name of injured Person (Last, First, Middle Initial) or Name of Injured Person (Last, First, Middle Initial)	
4. Mailing Address (Street, Apt. #, P.O. Box #)	
3. Area Code/Phone No.	6. Area Code/Work/Cell
5. Social Security #	8. Date of Birth (Month/Day/Year)
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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
Company Name	Group Name
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 Bureau'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.

1. Organization	
2. League Name	
3. State	5. Region
4. Injury occurred on <input type="checkbox"/> Event <input type="checkbox"/> Practice <input type="checkbox"/> Travel <input type="checkbox"/> Camp	
6. Nature of Injury	
4.b. Injury occurred on <input type="checkbox"/> Indoor Field <input type="checkbox"/> Outdoor Field	
8. Nature of Injury	
7. Name and Phone Number of Coach/Manager or Release Person (if victim 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 accident or 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 accident or injury, medical history, consultation, prescription, or treatment, and copies of all medical, medical or insurance records including, 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.

CAUTION: 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.

For residents 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 preparation of misleading information concerning any fact material thereto, and any person who knowingly makes or furnishes any such false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and is subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or vessel (or for each vessel).

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or consents for the preparation 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.

For residents not residing in 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 page applies to anyone using 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)



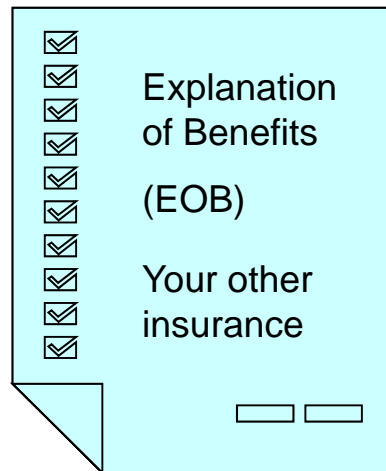
3) Part B must be fully completed, signed and dated by a local team/USASA organization official.

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:

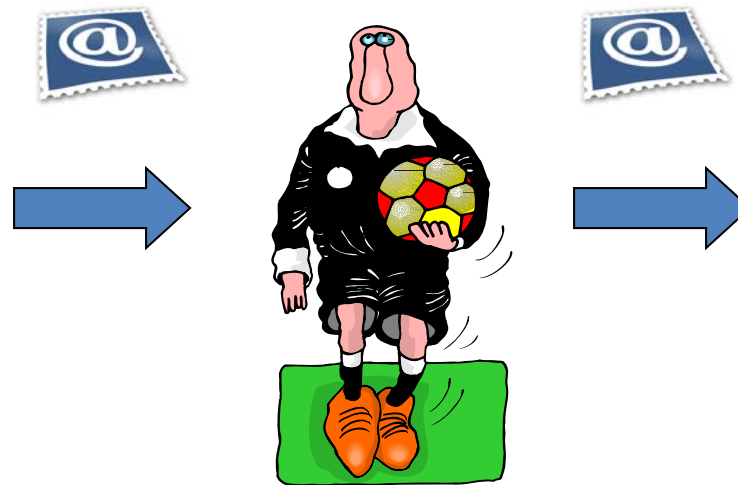




Step By Step Instructions (Continued)



USASA Verification Officer



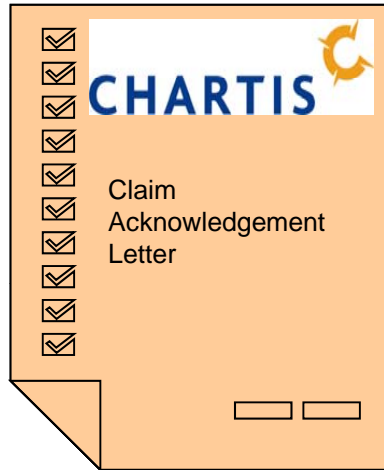
5) If you have medical coverage under another policy you must submit the bills to your primary insurer first and submit a copy of your primary insurer's Explanation of Benefits (EOB) statement along with the claim form to your State Verification Officer.





Step By Step Instructions

(Continued)



6) Your state verification officer will then sign and mail the FULLY COMPLETED claim form to Chartis. Upon receipt Chartis 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 Myriam Nuñez at (913) 495-4994 – (toll free) 800-551-0824 ext 4994.

