YOUTH SOCCER ACCIDENT PROOF OF LOSS

SEE REVERSE FOR INSTRUCTIONS

FLORIDA YOUTH SOCCER ASSOCIATION

An affiliate of US Youth Soccer Association, Inc.

TO BE COMPLETED BY CLAIMANT

NAME OF CLAIMANT (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐ Male

ADDRESS OF CLAIMANT (Street) (City) (State) (Zip code)	TELEPHONE NUMBER	OCCUPATION

DATE & TIME OF ACCIDENT	ACCIDENT DUE TO EMPLOYMENT? ☐ Yes ☐ No

FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT

_____

B. PLACE OF ACCIDENT (BE SPECIFIC)

_____

C. DESCRIBE HOW ACCIDENT HAPPENED

_____

D. IS YOUR LEAGUE RECREATIONAL _____ OR COMPETITIVE _____ (CHECK ONE)

MEDICAL AUTHORIZATION

I hereby authorize the release of any medical or other information necessary to process this claim, ircludina all data coverina this and/or previous confinements and/or disability.

Please Sign Here: _____

Claimant (if Adult) or Parent/Guardian — Date

I hereby authorize payment of benefits directly to the providers rendering services.

Please sign here: _____

Claimant (if Adult) or Parent/Guardian — Date

STATEMENT OF OTHER INSURANCE

1. Name and Address of Claimant's Employer: **(If a** minor, complete # **2** & **3)**

2. Father's Name or Guardian:	Occupation:	Name and Address of His Employer:	Phone #:
3. Mother's Name or Guardian:	Occupation:	Name and Address of Her Employer:	Phone #:

☐

Name of your Health Care Provider	**Address**

hereby certify, swear and affirm that the information given above **is** true and accurate. **I** fully understand that any wilful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature _____ Date _____

Claimant **(If** Adult) or Parent/Guardian

TO BE COMPLETED BY POLICYHOLDER / ADMINISTRATOR			
EFFECTIVE DATE OF COVERAGE	COVERAGE TERMINATION DATE, IF APPLICABLE	POLICY NUMBER	NAME OF GROUP POLICYHOLDER
9/01/02	9/01/03	4102AH243046	Florida Youth Soccer

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	(Zip Code)	TELEPHONE NUMBER
8034 Sunport Drive Suite 404	Orlando	FL	32809	407-852-6770

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.	DISTRICT COMMISSIONER	DATE
AUTHORIZED SIGNATURE:_____		

INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM:

1. **IMMEDIATELY** submit a claim for all medical expenses to the Company that administers your own personal or group insurance or healthcare plan (including Major Medical coverage). If you have coverage through an HMO or similar facility, you **must** use that facility first or the claim will not be covered under this policy.

2. After your other insurance or healthcare plan has paid the medical expenses up to the policy limits, attach any unpaid bills and copies of payments made by your insurance company (Explanation of Benefits) to this claim form and mail to the Florida Youth Soccer Association Insurance Administrator at the address shown below. Claims must be filed under this policy within 90 days of the date of accident.

3. Please check and make sure that:
   a) An Official or Administrator of the Policyholder has completed his/her section of the claim form.
   b) You have completed and signed the Parent/Guardian or Insured's Statement of other Insurance.
   c) The Medical Records Authorization **MUST** be signed and dated. If you want payments to be sent directly to your doctor or healthcare provider, sign the Payment Authorization Section.
   d) You have attached all unpaid bills to this form.
   e) You have attached any Explanation of Benefits forms that you have received from your Primary insurance carrier or other healthcare plan.
   f) You have completed the front of this form.

4. Subsequent bills should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new claim form is not necessary.**

5. Mail this claim form and all itemized bills to the Florida Youth Soccer Association's Insurance Administrator, M.E. Wilson. They will authorize your claim and forward it to Bollinger for processing.

M.E Wilson Co Inc
Attn: FYSA Claims
PO Box 373
Tampa, FL 33601
Phone: 813-229-8021 Fax: 813-229-2795

FLORIDA YOUTH SOCCER ASSOCIATION

6. Accident claims are processed by **Bollinger, Inc., Sports Accident Division, 830 Morris Turnpike, Short Hills, NJ 07078.** If you have any questions regarding your claim, please contact Bollinger at 1-800-526-1379, or by fax at 467-0759. Or, for more information on the FYSA Insurance Program, visit our web site at **www.BollingerSoccer.com,** and click on "Florida Youth Soccer Association".