

**ACCIDENT PROOF OF LOSS/CLAIM FORM**

COMPLETE AND RETURN THIS FORM TO:



P.O. Box 390 Short Hills, NJ 07078



Deductible: \$250

104 week eligibility period

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

1. **NAME:** (first) \_\_\_\_\_ (last) \_\_\_\_\_ **PHONE:** \_\_\_\_\_

2. **ADDRESS:** \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code) \_\_\_\_\_

3. **BIRTHDATE:** \_\_\_\_\_ **SEX:**  MALE  FEMALE

4. **CLAIMANT IS A:**  PLAYER  COACH  OFFICIAL  OTHER \_\_\_\_\_

5. **ACCIDENT DATE:** \_\_\_\_\_ **ACCIDENT TIME:** \_\_\_\_\_

6. **BODY PART INJURED:** \_\_\_\_\_

7. **ACCIDENT OCCURRED DURING:**  GAME  PRACTICE  TOURNAMENT  CAMP/CLINIC

8. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**  
 \_\_\_\_\_  
 \_\_\_\_\_

9. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:** \_\_\_\_\_

**SECTION II STATISTICAL INFORMATION (Required)**

1. **NAME OF TEAM/CLUB:** \_\_\_\_\_

2. **TYPE:**  COMPETITIVE  RECREATIONAL

3. **LOCATION:**  ON FIELD  INDOOR  SPECTATOR AREA  OTHER

4. **SURFACE:**  DIRT  GRASS  OUTDOOR TURF  INDOOR TURF

5. **SURFACE CONDITION:**  DRY/NORMAL  WET/RAINY  ICY  MUDDY

6. **POSITION:** \_\_\_\_\_

7. **STATUS:**  HIT BY OBJECT  COLLISION W/OPPONENT  COLLISION W/TEAMMATE  
 OTHER \_\_\_\_\_

**SECTION III TO BE COMPLETED BY AUTHORIZED OFFICIAL (Required)**

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER		
9/1/2006	9/1/2007	PST2256C	Virginia Youth Soccer		
ADDRESS OF POLICYHOLDER (Street)		(City)	(State)	(Zip)	TELEPHONE NUMBER
2239D Tackett's Mill Drive		Woodbridge	VA	22192	703-494-0030

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT.

YES-SPONSORED/SANCTIONED ACTIVITY

YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

**AUTHORIZED SIGNATURE:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SECTION IV STATEMENT OF OTHER INSURANCE (Required)**

**Other Insurance for Claimant/Father**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
SELF EMPLOYED  UNEMPLOYED

**Other Insurance for Claimant/Mother**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
SELF EMPLOYED  UNEMPLOYED

**If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.**

**IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY?**  YES  NO

INSURED NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ INSURED GRP#/NAME: \_\_\_\_\_  
COMPANY NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**Note: 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 V ASSIGNMENT OF BENEFITS**

**ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.**

**SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)**

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

**SIGNATURE OF PARENT/GUARDIAN/CLAIMANT (Required):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

2. 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 Bollinger Insurance or its representatives, 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 (Required):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## **IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED:**

1. **Accident Medical Expense Coverage** under this policy is provided on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e. to be treated in-network, if required by HMO, etc.) in order for this policy to consider your expenses for payment.
2. **Claim Guidelines:** You have **90 days** from date of injury to submit claim form.  
For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.  
  
**Benefit Period:** This policy is subject to a **104 week** eligibility period from date of injury. Medical or dental expenses that are incurred **within 104 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **104 week** benefit period will not be covered by this policy.
3. **Please Remember:**
  - a) An Official or Administrator of the Policyholder must complete their section of the claim form.
  - b) Please make sure you have completed the entire claim form and signed where required.
  - c) Please attach all itemized bills to this form. Subsequent bills can be sent in as you receive them with no additional claim forms. Each bill must show the following:
    1. Provider's Name, address and phone number
    2. Provider's Federal Tax ID#
    3. Dates of service
    4. Diagnosis Description or Codes (ICD-9)
    5. Procedure Description of Codes (CPT)
    6. Charge for each procedure
  - d) Please attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
4. **Dental Bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Bollinger Insurance.
5. **Flexible Spending Account:** You must submit your bills through your primary insurance carrier and Bollinger Insurance first before accessing your Flexible Spending Account within your company.

For further information contact:

Bollinger, Inc.  
Sports Claims Department  
P.O. Box 390  
Short Hills, NJ 07078-0390  
Phone: 1-866-267-0093  
[www.BollingerSoccer.com](http://www.BollingerSoccer.com)

**Bollinger**  
*Insurance Since 1876*