CLAIM FILING PROCEDURES (for office use only)

State Association Code: _____
Current League Code: _____
Current Team Code: _____

CLAIM PROCEDURE:

1. 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.
2. **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 benefits may be denied due to untimely filing.
3. Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your U.S.A.S.A. State Association office for validating.
4. 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.**
2. **ATTACH ALL BILLS.**
3. **MAIL TO:**

Louisiana Soccer Association
475 Gardere Lane
Baton Rouge, LA 70820

USA SOCCER
AMATEUR DIVISION

U.S.A.S.A.

Special Risk
ACCIDENT CLAIM FORM
Please print or type.

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 his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.

1. Name of Injured Person (Insured): *First/Middle/Last*	1a. Date of Accident: *Mo/Day/Year*
2. Complete Mailing Address: *Street/City/State/Zip*	
3. Area Code/Home Telephone #:	3a. Area Code/Work Phone #:
4. Social Security #:	5. Date of Birth: *Mo/Day/Year*
6. ☐ Male ☐ Female	6a. ☐ Single ☐ Married ☐ Full-time Student

7. Are you currently enrolled in any health insurance plan? ☐ Yes ☐ No
If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.

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. Have you ever been treated for this or a similar condition before? ☐ Yes ☐ No
If yes, last date treated: _____

7c. If you are self employed or unemployed and not covered under any health insurance plan, please sign below.
Signature: _____

PART B - This section MUST be completed, then signed by an official of your local organization.

1. Team Name:

2. League Name:

3. Injury Occurred at: ☐ Event ☐ Practice ☐ Travel ☐ Game

3a. Name of Event:

3b. Injury occurred on: ☐ Indoor Field ☐ Outdoor Field

4. Describe how accident occurred:

5. Type of Injury:

6. Name and Phone Number of Coach, Manager or Referee present at the time of the accident:

7. Signature: Title:

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc. or its representatives 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 accidental injury for which I am claiming insurance benefits.

I waive 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 K&K Insurance Group, Inc. or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, and copies of all hospital, medical or insurance records including, but not limited to, information regarding other insurance coverages. I agree that a photocopy of this authorization shall be considered as effective as the original.

(The above paragraphs are being used in order to facilitate our obtaining and providing proper information needed to quickly process your claim.)

Signature: _____ Date: _____

CLAIMS ADMINISTRATION BY K&K INSURANCE GROUP c/o YOUR STATE ASSOCIATION VERIFICATION OFFICER

U.S. AMATEUR SOCCER ASSOCIATION ACCIDENT AND HEALTH PLAN

ADDITIONAL INFORMATION

The Accident and Health Plan under the U.S.A.S.A. policy provides a supplementary/excess combined maximum benefit not to exceed $5,000 per incident after the incident deductible of $400 has been satisfied. Only allowable charges may be applied to the deductible or paid in accordance with policy limits. Medical charges for injuries incurred only at the time of the covered accident are eligible. The injured participant must seek treatment for the claimed accident within 60 days of the injury. Services other than those with pre-established maximums are subject to plan guidelines. (This is a benefit description only, not a guarantee of payment.) A more detailed summary of benefits will be provided to the participant upon request.

Claim forms with incomplete information will require additional information requests that delay payment. Should you receive a request for additional information, please respond promptly.

QUESTIONS & ANSWERS

1. **What is a Primary Carrier?**
   The Primary Carrier is the insurance company who will consider your medical expenses first and issue any eligible payments. A Primary Carrier is any Health Insurance Plan through your place of employment, a family plan through a relative's place of employment, a University health plan for college students, Retirement policy, or other accident policies and/or Medicare.

2. **What is Excess or Supplementary coverage?**
   This is a coverage that will reduce your out of pocket expenses after your Primary Health Insurance has paid your eligible medical expenses.

3. **What if I do not have any other Health Insurance?**
   Then, the U.S.A.S.A. plan will be considered the Primary Carrier. Keep in mind that if this is the case, it will not change policy limits, guidelines or procedures. You will be responsible for any difference between what the provider charged and what the insurance companies paid.

4. **What is considered an itemized bill?**
   An itemized bill will have all the following: the complete name, address, phone number and tax identification number of the provider (doctor or hospital). It will also have a diagnosis code, five digit procedure codes, dates and services rendered and the amounts charged.

5. **What is an Explanation of Benefits?**
   An Explanation of Benefits (commonly abbreviated EOB) is a statement your Health Insurance company sends to you whenever they process a claim. It will show the types of service, how much was allowed, how much was applied to a deductible and the amounts charged.

6. **How is payment calculated?**
   We look at what the provider charged (before primary carrier calculations) and determine the maximum allowable based on our limits. Then, we check to see if you have satisfied your accident deductible. If the deductible has not been satisfied, we subtract the deductible amount from the allowed charges. If there is a balance left, we then look to see what the primary carrier paid. This is deducted as well. Any balance due, after the above calculations, is remitted to the participant or health care provider.

7. **Do I have to fill out a claim form every time I submit bills?**
   No, additional forms are not needed once we have received your validated claim form. Additional medical bills and Explanation of Benefits can be sent directly to the insurance company for handling.

US ADULT SOCCER PLAN LIMITATIONS & EXCLUSIONS – 2003 - 2004

This statement is intended as a general description of excess, or secondary plan benefits available under the Participant Accident Policy. Please contact your state verification officer for further details.

All eligible expenses are subject to a $400 deductible.

SCHEDULED BENEFITS

Hospital Room & Board Expense (In-Patient)	$150, maximum per day
Hospital Miscellaneous (In-Patient)	$1,000, maximum per admission
Hospital/Facility Expense (Out-Patient)	$250 per admission
Hospital Emergency Care	$350, maximum per injury
Physician Expense (Non-Surgical)	$35, maximum per visit, limit 10 visits per injury
Surgeon Expense (in- or Out-Patient)	Allowed at 50% of usual, reasonable & customary (UCR) amount
Assistant Surgeon	Allowed at 25% of surgeon's UCR
Anesthesiologist	Allowed at 12.5% of surgeon's UCR
Physical therapy or Chiropractic expense	$25, maximum per visit, limit 10 visits per injury
X-rays (In- or Out-Patient) including diagnostic imaging, MRI, CAT scans, or similar procedures	$150, maximum per injury
Dental Expense (sound/natural teeth only)	$500, maximum per injury
Ambulance Expense	$100, maximum per injury
Orthopedic appliances or braces as a result of covered injury, NOT for the prevention of injury.	$400, maximum per injury

EXCLUSIONS

Hernia, any form
Fighting, unless an innocent victim
Expense incurred for the use of orthotics, unless exclusively to promote healing.
Prescription drugs
Rental/Purchase of electric, bio-mechanical devices, continuous passive motion devices (CPM), electrical stimulation
Any member of the Insured Person's family or household
Injury sustained while riding in or on any two-or three-wheeled vehicle, or motorized vehicle
Insect bites, poison oak, poison ivy, warts, blisters, ingrown nails, or any other similar condition
Intentional, self-inflicted injury
Injury sustained in the commission of or attempted commission of a criminal act
Illness or disease, except when treatment is necessitated by bodily injury caused by a covered accident
Injury caused while intoxicated or under the influence of drugs or narcotics unless prescribed by a licensed physician

PRE-EXISTING CONDITION LIMITATION

A time period of six (6) months whereby a previous condition must be treatment free is the criteria for a condition to be considered a "new" injury. Any chronic, pre-existing condition for which treatment has been recommended or received six (6) months prior to the effective date of the insured's enrollment , shall be covered to a maximum of $1,000.

PLAN MAXIMUM

$5,000 payable per injury subject to plan limits. Coverage ends 52 weeks from the date of the accident.