YOUTH SOCCER EXCESS ACCIDENT MEDICAL CLAIM

Administered by

Bene-Marc, Inc.
4255 Bryant Irvin Road, Suite 201
Fort Worth, Texas 76109
(817) 738-6899 ● Fax: (817) 738-1811

THE HARTFORD

HOW TO FILE A CLAIM

- Complete ALL questions on the Youth Soccer Association claim form. The claim form has four (4) pages.
- Have the coach or another local official, that witnessed the accident, sign **SECTION II** (WITNESS VERIFICATION.)
- Sign the claim form in **SECTION VI** (STATEMENT OF CERTIFICATION), **SECTION VII** (AUTHORIZATION TO ASSIGN BENEFITS), and **SECTION VIII** (AUTHORIZATION TO OBTAIN INFORMATION.)
- File this claim within 90 days of the date of accident. Do not wait until all your itemized bills have been processed by your other carrier.
- If you have other insurance, submit your itemized bills to the other carrier first. You will receive a payment explanation worksheet (EOB) from the other carrier.
- Attach any bills and payment explanation worksheets (EOBs) that have been processed by your other carrier to this claim form.
- ***Send this claim form to your State Association for verification and signature.***

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 Telephone #, Provider's Federal Tax ID #, Diagnosis Code (ICD-9) or Diagnosis Description, Date of Service, Procedure Code(s) (CPT) or Procedure Description, and Charge for each Procedure.
3. Additional bills to be submitted at a later date (after the initial submission of your claim) should be sent directly to BENE-MARC, INC. with the following information: Name of the participant, date of the accident, and name of the State Youth Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond to any correspondence requesting additional information promptly. It is the Parent/Guardian's responsibility to request this information from the provider of service or from your primary carrier.
6. A payment worksheet will be sent to you from THE HARTFORD showing how your claim was processed.

BENE-MARC, INC. 4255 BRYANT IRVIN ROAD, SUITE 201, FORT WORTH, TEXAS 76109 (817) 738-6899

CLAIMANT'S NAME: _____

SECTION VI STATEMENT OF CERTIFICATION

I/We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief.

I/WE UNDERSTAND, FRAUDULENT CLAIM SUBMISSION: ANY INCORRECT, MISLEADING OR UNDISCLOSED INFORMATION, AND ANY ATTEMPT TO COLLECT FULL PRIMARY BENEFITS IN EXCESS OF THE TOTAL COVERED EXPENSES UNDER TWO OR MORE GROUP INSURANCE PLANS IS CONSIDERED MAIL FRAUD AND WILL FALL UNDER FEDERAL JURISDICTION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING MATERIALLY FALSE INFORMATION OR CONCEALS INFORMATION CONCERNING ANY MATERIAL FACT, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I /We agree that all information provided in this document is accurate and complete to the best of my/our knowledge.

Permission is hereby granted for a licensed physician to administer any necessary medical treatment to the above-named athlete. Furthermore, I hereby authorize any insurance company, hospital, physician, and/or any other health care provider of the State Soccer Association to disclose or secure copies of all information and records with respect to injury, medical history, and any required data, including insurance policy coverage on the athlete as named above.

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT: _____ DATE: _____

SECTION VII AUTHORIZATION TO ASSIGN BENEFITS

I authorize payment of medical benefits payable under the ATHLETIC ACCIDENT INSURANCE TO:

Provider: ☐ Self: ☐ Other: ☐ _____

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT: _____ DATE: _____

SECTION VIII AUTHORIZATION TO OBTAIN INFORMATION

To all physicians; medical professionals; hospitals; clinics; other health care providers; insurers; employers; group policyholders; insurance support organizations; and, other persons who have information about the patient.

I/We authorize you to give THE HARTFORD, its reinsurers or its agents: (a) all information you have as to illness, injury, medical history, diagnosis, treatment and prognosis with respect to any physical or mental condition of the patient; (b) all employment information you have about the patient, and; (c) any other information you have about the patient which THE HARTFORD believes it needs to perform the functions described below.

The information obtained will be used: (a) to determine if the patient is eligible under a THE HARTFORD contract, and; (b) for any other purpose which relates to the contract.

This form will be valid as long as the claim lasts, I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT: _____ DATE: _____

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

BENE-MARC, INC.
4255 Bryant Irvin Road, Suite 201
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(817) 738-6899
Facsimile (817) 738-1811

POLICY #: _____

IMPORTANT

1. INSTRUCTIONS ON BACK
2. **THIS CLAIM FORM MUST BE MAILED TO YOUR STATE ASSOCIATION LISTED BELOW:**

ROGER J. BEST
ROCH. DIST. COMM.
21 ILAND DRIVE
ROCHESTER, NY 14624

THIS CLAIM MUST BE SENT TO THE STATE ASSOCIATION FOR VERIFICATION AND SIGNATURE

FOR CLAIMS ASSISTANCE, PLEASE CALL 1-800-738-0691

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: Participant ☐ 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: _____
    _____
    _____
    _____

SECTION II — WITNESS VERIFICATION

Signature of Person Witnessing Injury	Witness Name (print)	Date
Signature of Local Official	Local Official Name (print)	Date

SECTION III — ** TO BE COMPLETED BY AUTHORIZED STATE OFFICIAL ******

NAME OF STATE ASSOCIATION: _____

I, _____, certify that the above claimant was a registered participant or coach of the _____ Soccer League/Association at the time the accident occurred.

Signature of Authorized Official	Title	Date

THE HARTFORD

BENE-MARC, INC. 4255 BRYANT IRVIN ROAD, SUITE 201, FORT WORTH, TEXAS 76109 (817) 738-6899

CLAIMANT'S NAME: _____

SECTION IV PARENT/GUARDIAN INFORMATION

IF YOU ARE A COACH FILING A CLAIM ON YOURSELF, YOU MUST COMPLETE THIS PAGE.

FATHER / GUARDIAN / CLAIMANT

NAME: _____
S.S.#: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: (____)_____
EMPLOYER: _____
PHONE: (____)_____

MOTHER / GUARDIAN / CLAIMANT

NAME: _____
S.S.#: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: (____)_____
EMPLOYER: _____
PHONE: (____)_____

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 V STATISTICAL INFORMATION

1. NAME OF STATE ASSOCIATION: _____
2. NAME OF LOCAL ASSOCIATION OR LEAGUE: _____
3. NAME OF CLUB (if applicable): _____ 4. NAME OF TEAM: _____
5. AGE DIVISION: (U-12, U-10, etc.): _____ 6. COMPETITIVE: ☐ RECREATIONAL: ☐

7. **TIME:**	☐ MORNING	☐ AFTERNOON	☐ EVENING	☐ AFTER HOURS
8. **LOCATION:**	☐ ON FIELD	☐ SIDELINES	☐ SPECTATOR AREA	☐ OTHER
9. **DISPOSITION:**	☐ ON-SITE CARE ONLY	☐ AMBULANCE	☐ PERSONAL TRANSPORTATION	☐ REFUSED CARE
10. **SURFACE:**	☐ DIRT	☐ GRASS	☐ ARTIFICIAL TURF	☐ OTHER (Please list)
11. **POSITION:**	☐ GOALIE	☐ FORWARD	☐ DEFENDER	☐ OTHER (Please list)
12. **SITUATION:**	☐ HIT BY BALL	☐ COLLISION W/PARTICIPANT	☐ NON-CONTACT INJURY	☐ OTHER (Please list)