GUIDELINES FOR SUBMITTING A YOUTH SOCCER ACCIDENT CLAIM FORM

1. Complete ALL questions on the Youth Soccer Accident Claim Form.
2. Have the coach or another local official that witnessed the accident sign Section III (COACH OR LOCAL OFFICIAL VERIFICATION).
3. Sign the claim form in Section VI (STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION.)
4. File this new report of claim within 30 days of the date of accident or as soon thereafter as is reasonably possible.
5. If you have other insurance, submit your itemized bills to the other carrier first. You will receive a payment Explanation of Benefit worksheet (EOB) from your other carrier. Do NOT wait until your other carrier has processed all your bills before filing a Youth Soccer Accident Claim Form.
6. You may attach itemized bills and your other carrier’s EOBs that are ready at the time of submitting this Claim Form.
7. Send the Claim Form to your State Association for verification and authorized state signature. DO NOT SEND THE CLAIM FORM DIRECTLY TO PULLEN INSURANCE SERVICES.
8. Upon receipt of the claim form from your state association we will forward an acknowledgement form advising you of receipt of your claim. All future correspondence concerning your claim should be directed to K&K Insurance, who is the claims payor for National Union Fire Insurance Company, at the address and phone number listed on your acknowledgement.

HELPFUL REMINDERS

1. There is a $100 deductible per covered accident for the 9/1/09 - 9/1/10 policy year. Each claim is subject to a $50 physical therapy/chiropractic limit per visit/$2,000 total maximum.
2. Each itemized bill MUST show the following:
   - Provider of Service’s Name
   - Provider’s Address
   - Provider’s Federal Tax ID#
   - Provider’s Telephone #
   - Date of Service
   - Diagnosis Description or Codes (ICD-9)
   - Procedure Description or Codes (CPT)
   - Charge for each Procedure
3. Additional bills to be submitted at a later date (after the initial submission of your claim) should be mailed directly to K&K Insurance with the following information: Name of the claimant, date of the accident, and name of the State Youth Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond promptly to any correspondence requesting additional information. It is the Parent / Guardian / Claimant’s responsibility to request this information from the provider of service or from your primary carrier.
6. An Explanation of Benefits will be sent to you by K&K Insurance on behalf of National Union Fire Insurance Company.

MOST FREQUENTLY ASKED QUESTIONS

What is an itemized bill?
An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

What if I don’t have an itemized bill?
The Parent/Guardian must request this information from the provider of service. Some providers only mail a balance due statement. The claims payor, K&K Insurance, is unable to process this charge without an itemized bill. Again, request this information from the provider service. Explain that you have Youth Soccer Excess Accident Coverage.

Can you process this claim with my other insurance carrier’s worksheet alone?
No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

What if I don’t have my other carrier’s payment explanation (EOB)?
The Parent/Guardian must request the EOB from their other insurance carrier.
SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

1. Name: (LAST) ___________________________ (FIRST) ___________________________ (MIDDLE) ___________________________
2. Date of birth: ________ / ________ / ________ 3. Sex: □ Male □ Female
4. Home Address: (STREET) __________________________________________ (CITY) __________________________________________ (STATE) ___________________________ (ZIP CODE) __________
5. Type of claimant: □ Player □ Coach/Asst Coach □ Other: ___________________________
6. Accident date: ________ / ________ / ________
7. Description of injury (Indicate LEFT or RIGHT; i.e. Left Leg): __________________________________________
8. Did accident occur during (✓ all that apply) □ game □ practice □ tournament □ indoor soccer □ sanctioned/sponsored activities □ travel directly and interruptedly to or from activity premises
9. Describe how and where accident occurred: __________________________________________
10. Name of field / facility where accident occurred: __________________________________________

SECTION II STATISTICAL INFORMATION
1. Name of local association or league: __________________________________________
2. Name of club (if applicable): __________________________________________
3. Name of team: __________________________________________
4. Age Division: (U-12, U-10, etc): __________________________________________
5. □ Competitive □ Recreational
6. Time: □ Morning □ Afternoon □ Evening □ After Hours
7. Location: □ On Field □ Sidelines □ Spectator Area □ Other
8. Disposition: □ On-site Care Only □ Ambulance □ Personal transportation □ Refused care
9. Surface: □ Dirt □ Grass □ Artificial Turf □ Other (please list)
10. Surface condition: □ Dry □ Wet □ Icy □ Irregular
11. Position: □ Goalie □ Forward □ Defender □ Other (please list)
12. Activity: □ Running w/ ball □ Running w/o ball □ Defending □ Other (please list)
13. Situation: □ Hit by ball □ Collision w/ Participant □ Non-contact injury □ Other (please list)

SECTION III COACH OR LOCAL OFFICIAL VERIFICATION
_________________________ ___________________________ ___________________________
Signature of Coach or Local Official Coach or Local Official Name (print) Date

SECTION IV AUTHORIZED STATE OFFICIAL *
I, __________________________________________, of the __________________________________________ certify that the above claimant was a registered player, coach, assistant coach, or participant at the time the accident occurred.

_________________________ ___________________________ ___________________________
Signature of Authorized State Official Title Date

* Must be signed by the authorized state soccer association administrator with the state soccer office.
CLAIMANT’S NAME: ____________________________

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

SECTION V  PARENT / GUARDIAN / CLAIMANT INFORMATION

<table>
<thead>
<tr>
<th>Father / Guardian / Claimant</th>
<th>Mother / Guardian / Claimant</th>
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</thead>
<tbody>
<tr>
<td>Name: ______________________</td>
<td>Name: ______________________</td>
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<tr>
<td>Address: __________________</td>
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<td>City: _______________________</td>
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<td>Zip: ______________________</td>
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<td>Home Phone: (______) ______ - ______</td>
<td>Home Phone: (______) ______ - ______</td>
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<tr>
<td>Employer: __________________</td>
<td>Employer: __________________</td>
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<td>Phone: (______) ______ - ______ Ext. ________</td>
<td>Phone: (______) ______ - ______ Ext. ________</td>
</tr>
<tr>
<td>Email: ____________________</td>
<td>Email: ____________________</td>
</tr>
</tbody>
</table>

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 VI  STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION

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 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 where and to the extent allowed by state law.

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 National Fire Insurance Company or its representative, 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 ____________ Date ____________

SECTION VII  ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

Coverage Underwritten by

National Union Fire Insurance Company