AYSO ACCIDENT CLAIM FORM, Policy #US2065201

Part A – This Part MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under the age of 18 or otherwise dependent, by his / her Parent or Guardian.

Organization's Name: **American Youth Soccer Organization**

_____

Policy# : **US2065201**

_____

Organization's address: **19700 S. Vermont Ave. Suite 103, Torrance, CA 90502**

_____

Name of Injured Person:

_____

Name of Person Completing Form: _____.

Check one: Injured Person Parent Guardian

Provide the following information about the Injured Person:

Date of birth: _____ Social security number: _____

Gender of Injured Person: _____ Phone Number: _____

Address: _____ Email Address: _____

Employer address:_____

Employer phone number: _____

Is Injured Person covered under other health and / or accident insurance plans? (yes or no)_____

If answer is yes, indicate name of other insurance company: _____

Company's address: _____ Phone number: _____

Policy number(s): _____ Name of Policyholder(s): _____

If the Injured Person is under 18 or otherwise independent, give the following information:

Name of Father or Male Guardian: _____

Place of Employment: _____ Employer Phone No. _____

Name of Mother or Female Guardian: _____

Place of Employment: _____

Employer Phone No. _____

Explain HOW the accident and injury occurred and describe the nature of the injury.

_____

Part B – Must be completed by an AYSO Official.

Name of Injured Person:

_____

Signature of Regional Commissioner: _____ Date: _____

Signature of Safety Director: _____ Date: _____

Date of Accident/Injury:_____ Injury occured: Practice Travel Game Other_____

AYSO Region No. _____

AYSO Player / Volunteer ID No. _____

At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? (yes or no) _____

Name of Supervisor of Activity: _____

Was he/she a witness to the accident? (yes or no) _____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

PERSONAL INFORMATION NOTICE AND CONSENT: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by the Insurance Company named above or its representatives (the "Insurer") to assess my entitlement to benefits, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside the United States for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company or reinsurance company, workers compensation board or similar plan or organization, association or institution, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for a period of two (2) years from the date hereof, and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

REMITTING THE CLAIM FORM: When completed, claimant (or parent/guardian) should make copies of all documents and mail, fax, or email the claim form including itemized medical bills (if not mailed directly to AG Administrators by the medical providers) and copies of EOB's (explanation of benefits from primary insurance) to:

AG ADMINISTRATORS
PO Box 979, Valley Forge, PA. 19482 claims@agadmin.com ; Fax: 610-933-4122
If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact AG Administrators at 610-933-0800.

FRAUD NOTICE:

GENERAL: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OR CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT.
NEW YORK: 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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Patient's or Authorized Representative's Signature: _____ Date: _____

If Authorized Representative, Relationship to Patient: _____ Date: _____

Insurance is underwritten by US Fire Insurance Company.