

2009 ACCIDENT CLAIM FORM

AMERICAN YOUTH FOOTBALL & AMERICAN YOUTH CHEER

Instructions For Filling Out This Claim Form

(Should be read by League Presidents, Team Officials and Parents)

Our objective is to provide fast and accurate claims service. Listed below are some brief instructions that, when followed, will assist us in providing this service. Please keep in mind that we are not saying your claim will be paid, we are saying if all conditions are met, then this claim will be considered for payment.

WHEN TO FILE A CLAIM:

1. Since this policy contains an EXCESS MEDICAL EXPENSE BENEFIT, YOU MUST FIRST FILE THE CLAIM WITH YOUR EXISTING INSURANCE PLANS (including major medical) before we may determine what payments, if any, we owe. Note: If your family carrier is an HMO or PPO, you must always follow their rules for obtaining benefits.
2. Written proof of loss (the completed claim form and supporting documents) should be given to the Claims Administrator within 90 days after the loss starts.

HOW TO FILE A CLAIM:

All questions must be answered in FULL for us to process the claim. Failure to answer even one question, regardless of whether or not you think it is relevant, may result in the claim form being returned and subsequent delay.

There are four basic items that are required in order for a claim to be considered eligible for benefits. All claim forms received are initially enrolled, however, until all required information is received we are unable to review the claim for payment.

1) A COMPLETED POLICYHOLDERS REPORT (PART I) – Must Be Completed By Authorized Team / League Official

Please be sure to neatly and fully complete the claim form. If you do not have a claim form, please call (800) 622-7370 for assistance. The Policyholders Report must have a policyholder's authorized signature. The policyholder representative is the league administrator who acts on behalf of the policyholder to verify the claim. The policyholder is the sports organization that purchased the coverage.

2) A COMPLETED PROOF OF LOSS (PART II) – Must Be Completed By Injured Person Or Parent/Guardian If A Minor

Please be sure to neatly and fully complete the Proof of Loss for in its Entirety. If you do not have a Proof of Loss Form please call (800) 622-7370 for assistance. The proof of loss form must be signed by the injured person or his/her parent/guardian if injured person is a minor.

3) A COMPLETED INJURY REPORT (PART III – FOOTBALL AND PART IV - CHEER)

There are two different Injury Report forms included with this claim form. One injury report is for FOOTBALL related accident claims, and the other is for CHEER related accident claims. Please complete the correct form for the injury you are reporting. *This is a required form, and should be completed by the authorized team or squad official.* (Please be sure to answer ALL questions on this form.)

4) COPIES OF FULLY ITEMIZED BILLS

Please contact the providers of medical service directly for an itemized billing. An Itemized bill is usually in the HCFA-1500 or UB-92 format which means the bill should have a date of service, patient name, billing address and phone, provider tax identification number, procedural codes, and diagnosis code. If your bill does not have this information, please call the provider of service directly and request they mail it to us or call our office for assistance.

5) COPIES OF YOUR INSURANCE'S EXPLANATIONS OF BENEFITS

The policy selected by the policyholder is in excess to any other available source of medical benefits. This means that you must file your bills through your primary, or personal insurance carrier prior to this policy. When your insurance company processes the charges, they will send you an Explanation of Medical Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE. *(A \$100 deductible may apply.)*

IF YOU DO NOT HAVE ANY OTHER AVAILABLE INSURANCE COVERAGE, fully complete Section II of the claim form as directed above, indicating "NO" in response to each insurance question, if appropriate. You **MUST** sign the insurance portion of the form if you have no other coverage. Please remember that this is a signed and sworn legal document. *(A \$100 deductible may apply.)*

TO SUBMIT ADDITIONAL BILLS after the original claim form has been sent in, be sure to include the following: name of injured person/claimant, date of accident, name of league, claimant's social security number, and your League's 2009 Accident Insurance Policy Number.

We recommend that you always make a photocopy of the 2009 Accident Claim Form (pages 1-3), all itemized bills, etc. before forwarding to claims administrator.

For specific policy information, please call to verify benefits. It is important to remember that policy wording or any verbal verification of benefits does not guarantee payment. Some policies may have specific medical equipment exclusions or specific treatment type limitation, i.e., physical therapy or ambulance. It is important to remember that any statement of policy information does not guarantee the payment of any medical expense. Benefit determination can only be made once the entire claim and supporting documentation has been received and reviewed by the claims examiner.

Every policy has both an effective date (which must be prior to the injury date) as well as a benefit period, which is the period of time for which benefits are available for treatment to that injury. Treatment received past the benefit period is not eligible for benefits.

WHERE TO FILE CLAIM:

1. Send all completed forms, itemized bills, etc. to American Specialty Insurance & Risk Services, Inc. at the address shown below.
2. Any questions concerning the status of benefit payments should also be directed to American Specialty at the toll free phone number shown below:

American Specialty Insurance & Risk Services, Inc.
AYF / AYC Claims Administrator
P. O. Box 459
Roanoke, IN 46783
Phone: 1-800-566-7941
Fax: 260-673-1189

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AMERICAN YOUTH FOOTBALL & AMERICAN YOUTH CHEER 2009 SEASON - ACCIDENT CLAIM FORM

Underwritten by: ACE American Insurance Company

AMERICAN SPECIALTY®

Please Type or Print – Use Black Ink

POLICY NUMBER: PTP-N01882922

PART I – POLICYHOLDER’S REPORT (Must Be Completed By Authorized Team / League Official)

Fraud Warning: “It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.”

1. NAME OF ORGANIZATION THAT PURCHASED COVERAGE:	2. NAME OF TEAM:
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3. MAILING ADDRESS OF ORGANIZATION THAT PURCHASED COVERAGE:

Street _____ City _____ State _____ Zip _____

4. NAME OF INJURED/INSURED PERSON	2. SOCIAL SECURITY NUMBER _____/_____/_____	6. SEX	7. BIRTH DATE ____/____/____
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8. ADDRESS OF INJURED PERSON:

Street _____ City _____ State _____ Zip _____

9. DATE AND TIME OF ACCIDENT	10. PLACE WHERE ACCIDENT OCCURRED
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11. WAS INJURED PERSON A:
(Circle One): **Coach** **Manager** **Player** **Guest** **Volunteer** **Other (Desc):**

12. NATURE OF INJURY (INDICATE PART OF BODY INJURED – SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)

13. DESCRIBE HOW ACCIDENT OCCURRED – GIVE ALL POSSIBLE DETAILS – MUST BE A BODILY INJURY DUE TO ACCIDENT

14. Did accident occur (Circle “Yes” or “No” for each question)	15. Name/Type of activity/sport
a) While claimant was supervised..... Yes No	
b) During sponsored activity..... Yes No	
c) On activity premises..... Yes No	
d) While traveling to or from a regularly scheduled activity in a supervised group. Yes No	

16. The above named claimant/injured person is a regular member of the policyholder and was injured while a regular member of such team and in the manner described above.

17. SIGNATURE (Team/League Official)	18. TITLE	19. DATE
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20. MAILING ADDRESS OF TEAM / LEAGUE OFFICIAL

Street _____ City _____ State _____ Zip _____

21. DAYTIME PHONE FOR TEAM / LEAGUE OFFICIAL ()	22. EMAIL ADDRESS FOR TEAM / LEAGUE OFFICIAL
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PLEASE NOTE: American Specialty Insurance & Risk Services, Inc. also conducts business as A.S.I.R.S.I. Insurance Agency in the state of California, American Specialty Insurance & Risk Services Agency in the state of Michigan, and A.S. Insurance & Risk Services Agency in the state of New York.

Send all completed forms, itemized bills, etc. to American Specialty Insurance & Risk Services, Inc. at the address shown below:

American Specialty Insurance & Risk Services, Inc.
AYF / AYC Claims Administrator
P. O. Box 459
Roanoke, IN 46783
Phone: 1-800-566-7941
Fax: 260-673-1189

E-mail: claimspa@amerspec.com



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**AMERICAN YOUTH FOOTBALL &
AMERICAN YOUTH CHEER
2009 SEASON
PROOF OF LOSS**

Underwritten by: ACE American Insurance Company

**Send all completed forms, itemized bills, etc. to American Specialty
Insurance & Risk Services, Inc. at the address shown below:
American Specialty Insurance & Risk Services, Inc.
AYF / AYC Claims Administrator
P. O. Box 459
Roanoke, IN 46783
Phone: 1-800-566-7941 Fax: 260-673-1189**

PART II – PROOF OF LOSS (Must Be Completed By Injured Person or Parent/Guardian If A Minor)

IMPORTANT: This form must be completed in its ENTIRETY by the INJURED PERSON OR THE PARENT/GUARDIAN IF A MINOR.

1. NAME OF INJURED / INSURED PERSON	2. SOCIAL SECURITY NUMBER ____/____/____	3. SEX	4. BIRTH DATE ____/____/____
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5. MAILING ADDRESS INJURED PERSON:

Street _____ City _____ State _____ Zip _____

6. DAYTIME TELEPHONE #: ()	7. IS INJURED PERSON MARRIED? Yes No	8. IS INJURED PERSON A MINOR? Yes No
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9. DATE AND TIME OF ACCIDENT	10. NAME / LOCATION WHERE ACCIDENT OCCURRED (Please include City & State)
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10. ACTIVITY PARTICIPATING IN AT TIME OF INJURY:

11. DESCRIBE INJURY (INCLUDING PART OF BODY INJURED – SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)

12. DESCRIBE HOW ACCIDENT OCCURRED – GIVE ALL POSSIBLE DETAILS – MUST BE A BODILY INJURY DUE TO ACCIDENT

13. Is injured person a full-time student? Yes No If "yes", name of school attending:	14. If a full-time student, is student medical insurance available? Yes No
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15. Does injured person have medical insurance? Yes No If "yes", name of company:	16. Does parent/guardian or spouse have medical insurance for the injured person? Yes No If "yes", name of company:
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17. Does injured person have Medicaid coverage? Yes No	18. Does injured person have governmental funded insurance? Yes No
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19. NAME & MAILING ADDRESS INJURED PERSON'S EMPLOYER:

Employer Name: _____

Street _____ City _____ State _____ Zip _____

20. NAME & MAILING ADDRESS INJURED SOUSE'S EMPLOYER: (IF APPLICABLE)

Employer Name: _____

Street _____ City _____ State _____ Zip _____

21. NAME & MAILING ADDRESS PARENT'S EMPLOYER (MOTHER):

Employer Name: _____

Street _____ City _____ State _____ Zip _____

22. NAME & MAILING ADDRESS PARENT'S EMPLOYER (FATHER):

Employer Name: _____

Street _____ City _____ State _____ Zip _____

23. AFFIDAVIT: I, the undersigned, affirm that I have not knowingly, or with intent, injured, defrauded, or deceived any insurance company by filing a statement of claim containing any false, incomplete, or misleading information, and understand I would be guilty of a felony by doing so.

Signature of injured person (or parent/guardian if a minor) _____ Date Signed _____

24. 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, association, 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 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 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 the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I agree that a photographic copy of this Authorization shall be as valid as the original.
I understand that I for my authorized representative may request a cop of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

25. SIGNATURE OF CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR) _____ DATED: _____

26. MAILING ADDRESS CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR)

Street _____ City _____ State _____ Zip _____

27. DAYTIME PHONE FOR CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR) ()	28. EMAIL ADDRESS FOR CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR):
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PLEASE NOTE: American Specialty Insurance & Risk Services, Inc. also conducts business as A.S.I.R.S.I. Insurance Agency in the state of California, American Specialty Insurance & Risk Services Agency in the state of Michigan, and A.S. Insurance & Risk Services Agency in the state of New York.

