US Club Soccer Accidental Medical-Dental Insurance Claim Form (Youth)

Updated May 5, 2022

GENERAL:

US Club Soccer-registered members may use this form to file an accident medical/dental insurance claim for an injury that occurred during a US Club Soccer-sanctioned activity.

Policyholder: National Association of Competitive Soccer Clubs, doing business as US Club Soccer

Excess coverage: Accident medical expenses are covered under this policy on an excess basis, and benefits will only be paid under this plan after your own personal / group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc.) for this policy to consider your expenses for payment. Payment under this policy will be made according to usual and customary guidelines. This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area. Once the $500 deductible has been satisfied, benefits are payable at 80% of the allowable rate. Additionally, some benefits may be subject to internal policy limits.

Claim eligibility timing: For claims to be eligible for coverage, this form must be submitted no later than 90 days after the date of injury, and medical attention must be received no later than 60 days after the date of injury.

Benefit period: This policy is subject to a 52-week benefit period from date of injury. Medical or dental expenses that are incurred within 52 weeks of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the 52-week benefit period will not be covered by this policy.

INSTRUCTIONS:

1. **Submit this form to US Club Soccer.** The claimant, or a parent/guardian if the injured person is a minor, is to complete this form in its entirety (with the exception of the **Club/Member Organization Verification** and **US Club Soccer Authorization** sections) and email it to US Club Soccer at insurance@usclubsoccer.org. Please do not send bills, Explanation of Benefits (EOBs), or other information to US Club Soccer.

POST-SUBMISSION PROCESS:

2. **Internal US Club Soccer verification.** After you submit this form, US Club Soccer will review claim eligibility and verify the accident with the claimant's club/member organization.

3. **Post-verification claim status update.** You will receive an email with the claim status when the verification is complete. If approved, US Club Soccer will then submit the claim to A-G Administrators, the claims processor.

4. **Communication and instructions from A-G Administrators.** You will then receive communication from A-G Administrators with instructions for you/your providers to submit documentation (bills, EOBs, etc.) directly to:

A-G Administrators	Email: claims@agadm.com
PO Box 21013	Phone: (610) 933-0800
Eagan, MN 55121	Fax: (610) 933-4122

Itemized bills are required:

- **HCFA-1500**: Standard form used by providers, such as doctors and dentists, to show the medical treatments and charges made for each service.
- **UB-04 or UB-92:** Standard form used by hospitals to show medical treatments / charges made for services.
- **Explanation of Benefits (EOB)** from your primary insurer(s), if applicable.

Payments will be made to you, if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider. All dental bills must be submitted through your primary insurance's medical and dental plans first before making a claim for dental treatment under this policy.

CLAIMANT INFORMATION:

1. **First name:** _____ | **Last name:** _____
2. **Address:** _____

   City: _____ | **State:** _____ | **ZIP Code:** _____
3. **Telephone #**: _____ | 4. **Email address:** _____
5. **Claimant is a**: ☐ Player | ☐ Staff member (coach, manager, etc.) | ☐ Official | ☐ Other: _____
6. **Gender:** ☐ Male | ☐ Female
7. **Date of birth:** _____ / _____/ _____ | 8. **Last four of Social Security #**: XXX-XX-_____
9. **Club / member organization name:** _____
10. **Team name:** _____

ACCIDENT INFORMATION:

11. **Date of accident:** _____ / _____/ _____ | **Time of accident:** _____
12. **Body part injured:** _____
13. **Accident occurred during:** ☐ Game (league/competition: _____) | ☐ Practice/Scrimmage | ☐ Tournament: _____ | ☐ Camp/clinic: _____ | ☐ Other: _____
14. **Describe accident & where it occurred:**_____

    _____

    _____
15. **Field/facility name & city/state where the accident occurred:** _____

    _____
16. **Location of accident:** ☐ On field | ☐ Indoors | ☐ Spectator area | ☐ Other: _____
17. **Surface:** ☐ Grass | ☐ Outdoor turf | ☐ Indoor turf | ☐ Dirt | ☐ Other: _____
18. **Surface condition:** ☐ Dry/normal | ☐ Icy | ☐ Wet/rainy | ☐ Muddy | ☐ Other: _____
19. **Type of accident:** ☐ Hit by object | ☐ Non-contact injury | ☐ Collision | Other: _____

CONTACT INFORMATION:

20. **First name:** _____ | **Last name:** _____
21. **Relationship to claimant:** ☐ Parent / guardian | ☐ Self | ☐ Spouse | Other: _____
22. **Address:** _____

    City: _____ | **State:** _____ | **ZIP Code:** _____
23. **Telephone #**: _____ | 24. **Email address:** _____

24. **Employment status:** ☐ Employed: _____ | ☐ Self-employed | ☐ Retired / not employed

OTHER INSURANCE INFORMATION:

25. **Does the claimant have primary insurance:** ☐ Yes | ☐ No

26. **If yes, provide insurance information:** Insurance company name: _____

Address: _____

City: _____ | State: _____ | ZIP Code: _____

Telephone #: _____ | Email address: _____

Policyholder name: _____

CLAIMANT (OR PARENT/GUARDIAN) AUTHORIZATION:

AFFIDAVIT: I verify that the statement on the other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. mail may be fraudulent and violate federal laws, as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any health care provider, doctor, medical professional, medical facility, insurance company, person or organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____ _____

Claimant signature *(parent/guardian if claimant is a minor)* Date

_____ _____

Name Relationship to claimant

CLUB/MEMBER ORGANIZATION VERIFICATION:

To be completed by a US Club Soccer-registered staff member of the claimant's club/member organization who was present at the time of the accident.

☐ **I was present at the time of the accident, and to the best of my knowledge, all of the answers to the questions in this form are accurate; OR**

☐ **I was present at the time of the accident, and to the best of my knowledge, some of all of the answers to the questions in this form is inaccurate in the following ways** (attach a separate sheet if necessary)**:** _____

_____

_____

Is the claimant registered with another U.S. Soccer Organization Member (ex: a state association): ☐ Yes | ☐ No

If yes, has the claim also been submitted to the other U.S. Soccer Organization Member: ☐ Yes | ☐ No

_____ _____

Signature Date

_____ _____

Name Position

US CLUB SOCCER AUTHORIZATION:

To be completed by US Club Soccer staff.

Was the claimant registered with US Club Soccer at the time of the accident: ☐ Yes | ☐ No

Did the accident take place during a US Club Soccer-sanctioned activity: ☐ Yes | ☐ No

_____ _____

US Club Soccer signature Date

_____ _____

Name Position

FRAUD WARNING:

Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

California & Texas Residents: Any person who knowingly presents a 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.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: 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.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York Residents: 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.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.