

COMPLETE AND RETURN THIS FORM TO:

ACCIDENT PROOF OF LOSS/CLAIM FORM



P.O. Box 390 Short Hills, NJ 07078

\$500.00 Deductible

104 week benefit period

SECTION I TO BE COMPLETED BY CLAIMANT/PARENT (required)

1. **NAME:** (first) _____ (last) _____

2. **ADDRESS:** _____ (city) _____ (state) _____ (zip code) _____

3. **TELEPHONE #:** _____

4. **BIRTHDATE:** ___/___/___ **SEX:** Male Female

5. **CLAIMANT IS A:** Youth Player Adult Player Coach Trainer Official Other _____

6. **CLAIMANT IS A:** Elite Player Regular Player

7. **USFHA MEMBER ID#:** _____ **USFHA CERTIFICATE OF INSURANCE #:** _____

7. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ am pm

8. **BODY PART INJURED:** _____

9. **ACCIDENT OCCURRED DURING:** Game Practice Tournament Camp/Clinic

10. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:** _____

11. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:** _____

SECTION II STATISTICAL INFORMATION (required)

1. **NAME OF TEAM/CLUB:** _____

2. **TYPE:** COMPETITIVE RECREATIONAL

3. **LOCATION:** ON FIELD SIDELINES SPECTATOR AREA OTHER _____

4. **SURFACE:** DIRT GRASS TURF

5. **SURFACE CONDITION** DRY/NORMAL WET/RAINY ICY MUDDY

6. **POSITION:** GOALIE FORWARD DEFENDER OTHER _____

7. **ACTIVITY:** RUNNING W/BALL RUNNING W/OUT BALL DEFENDING OTHER _____

8. **STATUS:** HIT BY BALL COLLISION W/PLAYER COLLISION W/OBJECT

OTHER _____

SECTION III TO BE COMPLETED BY U.S. FIELD HOCKEY (required)

POLICY #: 4102AH026985

NAME OF POLICYHOLDER: U.S. FIELD HOCKEY ASSOCIATION

ADDRESS OF POLICYHOLDER: 1 OLYMPIC PLAZA COLORADO SPRINGS, CO 80909 PHONE #: 719-866-4567

VERIFY THAT ACCIDENT OCCURRED DURING AN APPROVED U.S. FIELD HOCKEY EVENT.

YES-SPONSORED/SANCTIONED ACTIVITY

YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

AUTHORIZED SIGNATURE: _____

TITLE: _____

DATE: _____

SECTION IV**STATEMENT OF OTHER INSURANCE****(required)****Claimant/Father**

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

EMPLOYER: _____

PHONE: _____

SELF EMPLOYED UNEMPLOYED **Claimant/Mother**

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

EMPLOYER: _____

PHONE: _____

SELF EMPLOYED UNEMPLOYED

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NOIS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES NO

INSURED NAME: _____ ID#: _____ INSURED GRP#/NAME: _____

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

****Please include copy of insurance card (both sides)**

Note: 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**ASSIGNMENT OF BENEFITS**

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required): _____ DATE: _____

2. 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 Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required): _____ DATE: _____

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. Accident medical expense coverage under this policy is provided on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or 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) in order for this policy to consider your expenses for payment.

2. Claim Guidelines: You have **90** days from date of injury to submit claim form.

For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.

Benefit Period: 104-weeks: This policy is subject to a **104-week** eligibility period from date of injury. Medical or dental expenses that are incurred **within 104 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **104-week** benefit period will not be covered by this policy.

3. Please remember:

- a) An Official or Administrator of the Policyholder must complete their section of the claim form.
- b) Please make sure you have completed the entire claim form and signed where required.
- c) Please attach all itemized bills to this form. Subsequent bills can be sent in as you receive them with no additional claim forms.

Each bill must show the following:

1. Provider's Name, address and phone number
 2. Provider's Federal Tax ID#
 3. Dates of service
 4. Diagnosis Description or Codes (ICD-9)
 5. Procedure Description Codes (CPT)
 6. Charge for each procedure
- d) Please attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Bollinger Insurance.

5. **Flexible Spending Account:** You must submit your bills through your primary insurance carrier and Bollinger Insurance first before accessing your Flexible Spending Account within your company.

For further information contact:

Bollinger, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
www.BollingerInsurance.com

Send this claim form for authorization to:

U.S. Field Hockey Association
1 Olympic Plaza
Colorado Springs, CO 80909
Phone: 719-866-4567
Fax: 719-632-0979
Email: usfieldhockey.com

