CLAIM INSTRUCTIONS

AYSO Soccer Accident Insurance (SAI)

These instructions are to be used for completing the **SAI CLAIM FORM for inquiries starting July 1, 2019!**

***Note: The claim form AS FOLLOWS should be submitted to AIG Accident & Health (US) – addressed below–as soon as possible after medical treatment has been administered for an injury and not later than 90 days after an injury date. Submit the claim form to AIG to ensure notification is received timely. Once the primary carrier has paid send a copy of the itemized bill and primary carrier Explanation of Benefits (EOB) to AIG for additional benefit consideration. Keep copies of everything sent to AIG.*

Policies with Excess Coverage

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all **EOB's** from the primary insurance.

Claim Form

The claim form must be submitted for each individual claim. **Section A** must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. **Section B** must be completed in full and signed by the American Youth Soccer Organization (AYSO) Officials- **Regional Commissioner and Safety Director!** ***A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.***

Deductible ($1,000 and 20% Member coinsurance)

Each claim is subject to the $1,000 deductible and 20% member coinsurance. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

Medical Bills

Notify all medical providers – hospitals and doctors – if you will be using this insurance. Provide them with the name and mailing address of AIG (provided below) when requesting they submit the required insurance billing forms. A physician's office should submit a CMS 1500. A hospital and/or emergency room should submit a UB04. **A balance due statement is not acceptable and will only delay processing.**

Information Requests

In the event that a claim form is not submitted in full or if additional information is needed, the claim will be suspended, and the additional information will be requested via US mail. Please forward the information immediately to AIG, so that they may finish adjudicating your claim in a swift manner.

Claim Submission Checklist – FOR INJURIES THAT OCCURRED STARTING JULY 1, 2019

Use the below checklist to assure a properly submitted medical claim is to be sent.

	Yes	No
If the injured person has primary health insurance, the claim has been submitted first to the primary.		
If claim was first submitted to the primary, copies of the EOB's ***if available*** are attached.		
You have requested itemized medical bills - CMS1500 or UB04 - t o be ***sent directly to AIG.*** • ***Address: AIG Accident & Health Claims, Po Box 25987, Shawnee Mission, KS 66225***		
Part B been completed and signed by the AYSO Regional Commissioner and Safety Director.		
I have reviewed the SAI benefits as described at http://www.ayso.org under For Families, Insurance.		
Claim forms are NOT being submitted prior to MEDICAL SERVICES being performed.		

Mailing the Claim

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

AIG Accident & Health Claims, Po Box 25987, Shawnee Mission, KS 66225

*(**Tip**: We recommend mailing everything Certified/Return Receipt and to keep copies of all documents)*

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at 800-551-0824.

AYSO ACCIDENT CLAIM FORM – REGISTERED YOUTH PROGRAM

AIG Accident & Health Claims

PO Box 25987 **Shawnee Mission, KS 66225 Phone: 800-551-0824** www.aig.com

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.

1. Name of Organization
American Youth Soccer Organization (AYSO) Youth Program

2. Policy No.
SRG 0009156418 **(Registered YouthProgram)**

3. Address of Organization (Street) **19750 S Vermont Ave Ste 200** (City) **Torrance** (State) **CA** (Zip) **90502**

4. Name of Injured Person (Insured) (First) (Middle) (Last)

Print Here – Name of Person Completing Form:

Check one: ☐ Injured Person ☐ Parent ☐ Guardian

Give the following information about the Injured Person:

5. Date of Birth (Mo / Dy / Yr)

6. ☐ Male ☐ Female

7. Social Security No.

8. Area Code / telephone No.

9. Address: (Street) (City) (State) (Zip)

Email Address

10. Employer (Name) Address (Street) (City) (State) (Zip)

Area Code / Employer Phone No:

11. If the Injured Person covered under any other health and / or accident insurance plans? ☐ Yes ☐ No If YES, Give the following information:

Name of Other Insurance Company: | Address of Other Insurance Company: | Policy Number(s) | Name of Policyholder(s)

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

Name of Father or Male Guardian | Place of Employment | Area Code / Employer Phone No.

Name of Mother or Female Guardian | Place of Employment | Area Code / Employer Phone No.

13. If the Injured Person is married, give the following information:

Name of Spouse | Place of Employment | Area Code / Employer Phone No.

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

PART B – This Part MUST be completed by an AYSO Official.

1. Date of Accident / Injury (Mo / Dy / Yr)

2. Injury Occurred: ☐ Practice ☐ Travel ☐ Game ☐ Other: ____________________

3. AYSO Region No.

4. AYSO Player / Volunteer ID No.

5. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? ☐ Yes ☐ No

6. Name of Supervisor of Activity

7. Was he / she a witness to the accident? ☐ Yes ☐ No

8.Signature of Regional Commissioner
X________________________________

9. Date Signed

10. Signature of Safety Director
X ________________________________

11. Date Signed

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.

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.

Patient’s or Authorized Representative’s Signature: **X**________________________________ | Date Signed:

If Authorized Representative, Relationship to Patient:

Or Legal Designation Address (Street) (City) (State) (Zip)

State Fraud Notices

For Use on All Applications and Claim Forms

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.

ALASKA: A person who knowingly and with intents to insure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law,

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, LOUISIANA, MARYLAND, WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

COLORADO: 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.

CONNECTICUT: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

DELAWARE, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: 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: 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.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

MICHIGAN, NORTH DAKOTA, SOUTH DAKOTA: Any person who knowingly and with intent to defraud any insurance company or another person files a 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 subjects the person to criminal and civil penalties.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

NEW HAMPSHIRE: Any person who, with a purpose to inure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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.

OHIO: Any person who, with 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 is guilty of insurance fraud.

OKLAHOMA: Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA: 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 I a crime and subjects such person to criminal and civil penalties.

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

TEXAS: 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.

Insurance is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. and The Insurance Company of the State of Pennsylvania. AIG Claims, Inc. is an authorized claims administrator for National Union Fire Insurance Company of Pittsburgh, Pa. and The Insurance Company of the State of Pennsylvania.

View the U.S. Privacy policy at www.aig.com/privacy-policy.