CLAIM INSTRUCTIONS
AYSO Soccer Accident Insurance (SAI)

These instructions are to be used for completing the **SAI CLAIM FORM** for covered injury expenses incurred on or after July 1, 2016!

***Note: The claim form AS FOLLOWS should be submitted to Mutual of Omaha – address 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 Mutual of Omaha. Once the primary carrier has paid send a copy of the itemized bill and primary carrier's Explanation of Benefits (EOB) to Mutual of Omaha. Keep copies of everything sent.*

Excess Coverage
Eligible covered expenses will be paid 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 the itemized bills and all EOB's from the primary insurance carrier to Mutual of Omaha.

Claim Form
The claim form must be submitted for each individual injury/sickness (claim). **Section A** must be completed in full and signed by the injured person or the parent or guardian if that injured person is a minor. **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, allowable expense guidelines, or plan maximums may not be credited towards the deductible.

Medical Bills
Notify all medical providers - hospitals and doctors - you will be using this insurance. Provide them with the name and mailing address of Mutual of Omaha (see 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 requested information immediately to Mutual of Omaha (address below), so that they may finish adjudicating your claim in a swift manner.

Claim Submission Checklist – FOR COVERED INJURY/SICKNESS EXPENSES INCURRED ON OR AFTER JULY 1 2016.

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 insurance carrier.		
If claim was first submitted to the primary insurance carrier, copies of the EOB's ***if available*** are attached.		
You have requested itemized medical bills - CMS1500 or UB04 - t o be ***sent directly to Mutual of Omaha.*** • ***Address: Special Risk Services, P.O. Box 31156, Omaha, NE 68131***		
Part B of the Claim Form has been completed and signed by the AYSO Regional Commissioner and Safety Director.		
I have reviewed the SAI policy 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 Mutual of Omaha by the medical providers)* and copies of EOB's *(explanation of benefits from primary insurance carrier)* to:

Special Risk Services, P.O. Box 31156, Omaha, NE 68131
*(**Tip**: We recommend keeping 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 800-524-2324.

AYSO ACCIDENT CLAIM FORM – REGISTERED YOUTH PROGRAM

Special Risk Services; PO Box 31156; Omaha, NE 68131
Phone: 800-524-2324 www.mutualofomaha.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	2. Policy No.
American Youth Soccer Organization (AYSO) Youth Program	**SR2014-P-110169 (Registered Youth Program)**

3. Address of Organization (Street)	(City)	(State)	(Zip)
19750 S Vermont Ave, Suite 200	**Torrance**	**CA**	**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. Area Code / telephone No.	8. Email Address

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

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

Area Code / Employer Phone No:

11. Is 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 dependent, 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 the accident and HOW injury/sickness occurred and describe the nature of the injury/sickness.

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

1. Date of Accident / Injury/Sickness (Mo / Dy / Yr)	2. Injury/Sickness 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	9. Date Signed	10. Signature of Safety Director	11. Date Signed
X _____		X _____	

AUTHORIZATION TO RELEASE INFORMATION:

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

Claimant's or Authorized Representative's Signature: X_____ | Date Signed

If Authorized Representative, Relationship to Claimant:

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

STATEMENT OF CERTIFICATION:

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York Claimants: 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. (PURSUANT TO 11 NYC RR86)

Claimant's or Authorized Representative's Signature: X_____ | Date Signed:

If Authorized Representative, Relationship to Claimant:

State Fraud Notices

For Use on All Claim Forms

The following fraud language is attached to, and made a part of this claim form.

GENERAL – Any person who knowingly and with intent to injure, defraud or deceive any insurer or insurance company files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

ALABAMA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, 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, RHODE ISLAND: 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: 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 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.

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

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, 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 RSA 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.

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.

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 is 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.