SOUTH CAROLINA YOUTH SOCCER ASSOCIATION
ACCIDENT MEDICAL CLAIM FORM

GUIDELINES FOR SUBMITTING A YOUTH SOCCER ACCIDENT CLAIM FORM

1. Complete **ALL** questions on the Youth Soccer Accident Claim Form.
2. Have the coach or another local official that witnessed the accident sign **Section III** (COACH OR LOCAL OFFICIAL VERIFICATION).
3. Sign the claim form in **Section VI** (STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION.)
4. File this new report of claim within 90 days of the date of accident or as soon thereafter as is reasonably possible.
5. If you have other insurance, submit your itemized bills to the other carrier first. You will receive a payment Explanation of Benefit worksheet (EOB) from your other carrier. Do **NOT** wait until your other carrier has processed all your bills before filing a Youth Soccer Accident Claim Form.
6. You may attach itemized bills and your other carrier's EOBs that are ready at the time of submitting this Claim Form.
7. Send the Claim Form to your State Association for verification and authorized state signature.
8. Upon receipt of the claim form from your state association K&K Insurance will forward an acknowledgement form advising you of receipt of your claim. All future correspondence concerning your claim should be directed to K&K Insurance at the address and phone number listed on your acknowledgement.

HELPFUL REMINDERS

1. There is a $1,000 deductible per covered accident for the 9/1/20- 9/1/21 policy year. Each claim is subject to a $50 physical therapy/chiropractic limit per visit/$2,000 total maximum. **Failure to follow the rules of your primary healthcare coverage will result in a benefit reduction of eligible expenses to 50% of the amount otherwise payable.**
2. Each itemized bill MUST show the following:
   - Provider of Service's Name
   - Provider's Address
   - Provider's Federal Tax ID#
   - Provider's Telephone #
   - Date of Service
   - Diagnosis Description or Codes (ICD-10)
   - Procedure Description or Codes (CPT)
   - Charge for each Procedure
3. Additional bills to be submitted at a later date (after the initial submission of your claim) should be mailed directly to K&K Insurance with the following information: Name of the claimant, date of the accident, and name of the State Youth Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond promptly to any correspondence requesting additional information. It is the Parent / Guardian / Claimant's responsibility to request this information from the provider of service or from your primary carrier.
6. An Explanation of Benefits will be sent to you by K&K Insurance.

MOST FREQUENTLY ASKED QUESTIONS

What is an itemized bill?
An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

What if I don't have an itemized bill?
The Parent/Guardian must request this information from the provider of service. Some providers only mail a balance due statement. K&K Insurance is unable to process this charge without an itemized bill. Again, request this information from the provider service. Explain that you have Youth Soccer Excess Accident Coverage.

Can you process this claim with my other insurance carrier's worksheet alone?
No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

What if I don't have my other carrier's payment explanation (EOB)?
The Parent/Guardian must request the EOB from their other insurance carrier.

POLICY NUMBER:
BAX-301291-00

POLICY YEAR: 9/1/20 – 9/1/21

IMPORTANT
This claim form must be mailed to your state association listed below:

South Carolina Youth Soccer Association
7436 Broad River Road, Building 2, Suite 211
Irmo, SC 29063

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

1. Name: (LAST)_______________________________(FIRST)_______________________________(MIDDLE) ____________
2. Date of birth: _______ / ______ / ______ 3. Sex: ☐ Male ☐ Female
4. Home Address: (STREET)____
   (CITY) ______________________________ (STATE) ________________________ (ZIP CODE) _________
5. Type of claimant: ☐ Player ☐ Coach/Asst Coach ☐ Other: ________________________________
6. Accident date: _______ / ______ / ______
7. Description of injury (Indicate LEFT or RIGHT; i.e. Left Leg): ______________________________________
   ____
8. Did accident occur during (✓ all that apply) ☐ game ☐ practice ☐ tournament ☐ indoor soccer
   ☐ sanctioned/sponsored activities ☐ travel directly and interruptedly to or from activity premises
9. Describe how injury was sustained:____
   ____
10. Name of field / facility where accident occurred: ____

SECTION II STATISTICAL INFORMATION

1. Name of local association or league: ____
2. Name of club (if applicable): ___________________________ 3. Name of team: _______________
4. Age Division: (U-12, U-10, etc): ___________________________ 5. ☐ Competitive ☐ Recreational

6. Time:	☐ Morning	☐ Afternoon	☐ Evening	☐ After Hours
7. Location:	☐ On Field	☐ Sidelines	☐ Spectator Area	☐ Other
8. Disposition:	☐On-site Care Only	☐ Ambulance	☐ Personal transportation	☐ Refused care
9. Surface:	☐ Dirt	☐ Grass	☐ Artificial Turf	☐ Other (please list)
10. Surface condition:	☐ Dry	☐ Wet	☐ Icy	☐ Irregular
11. Position:	☐ Goalie	☐ Forward	☐ Defender	☐ Other (please list)
12. Activity:	☐ Running w/ ball	☐ Running w/o ball	☐ Defending	☐ Other (please list)
13. Situation:	☐ Hit by ball	☐ Collision w/ Participant	☐ Non-contact injury	☐ Other (please list)

SECTION III COACH OR LOCAL OFFICIAL VERIFICATION

______________________________ ______________________________ ____________________
Signature of Coach or Local Official — Coach or Local Official Name (print) — Date

SECTION IV AUTHORIZED STATE OFFICIAL *

I, ______________________________________, of the _________________________________ certify that the above claimant was a registered player, coach, assistant coach, or participant at the time the accident occurred.

______________________________ ______________________________ ____________________
Signature of Authorized State Official — Title — Date

* Must be signed by the authorized state soccer association administrator with the state soccer office.

CLAIMANT'S NAME: ____

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

SECTION V PARENT / GUARDIAN / CLAIMANT INFORMATION

Father / Guardian / Claimant

Name: ______________________________

Address: ______________________________

City: ______________________________

State: ______________ Zip: __________

Home Phone: (______) ______ - ______

Employer: ______________________________

Phone: (______) ______ - ______ Ext. __________

Email: ______________________________

Mother / Guardian / Claimant

Name: ______________________________

Address: ______________________________

City: ______________________________

State: ______________ Zip: __________

Home Phone: (______) ______ - ______

Employer: ______________________________

Phone: (______) ______ - ______ Ext. __________

Email: ______________________________

Is claimant covered under ANY other insurance policy? ☐ Yes ☐ No

Company Name: ____

Address: ____

City: ______________________________ State: ______________ Zip: __________

Phone: (______) ______ - ______

Insured Name: ____

Insured ID #: ______________________________ Insured Group # / Name: ______________________________

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 VI STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION

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 be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

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 K&K Insurance or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

______________________________ ______________________________

Signature of Parent / Guardian / Claimant Date

SECTION VII ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

Coverage Underwritten by: Nationwide Life Insurance Company
Claims Administrator: K&K Insurance Group
1-800-237-2917

APPLICABLE IN ALABAMA
Any person who knowingly presents a 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.

APPLICABLE IN 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.

APPLICABLE IN 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.

APPLICABLE IN ARKANSAS, DELAWARE, KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, VIRGINIA, AND WEST VIRGINIA
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, subject to criminal prosecution and [NY: substantial] civil penalties. In LA, ME, TN, and VA, insurance benefits may also be denied.

APPLICABLE IN CALIFORNIA
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

APPLICABLE IN THE 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.

APPLICABLE IN FLORIDA
Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or S. 775.084, Florida Statutes.

APPLICABLE IN 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.

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

APPLICABLE IN 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.

APPLICABLE IN 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.

APPLICABLE IN MARYLAND
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

APPLICABLE IN NEVADA
Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

APPLICABLE IN NEW HAMPSHIRE
Any person who, with 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.

APPLICABLE IN OHIO
Any person who, with intent to defraud or knowing that he/she 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.

APPLICABLE IN 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.

APPLICABLE IN WASHINGTON
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.

FRAUD CLAIMS (2016/04)

Dear Participant: If you have an appointment with a doctor as the result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates: