



U.S. SOCCER INCIDENT REPORT



(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> OTHER: _____
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: <u>Development Academy Event</u> EVENT TYPE: _____ SANCTIONED BY: <u>U.S. Soccer</u> LOCATION: _____ CLUB NAME: _____ CITY: _____ STATE: _____
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female PHONE: (____) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> TRAINING CENTER <input type="checkbox"/> COACH <input type="checkbox"/> TRYOUT
APPARENT INJURY	BODY PART: _____ CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY
OCCASION	<input type="checkbox"/> PRACTICE <input type="checkbox"/> GAME
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
INSURED	NAME OF INSURED: <u>U.S. Soccer</u> POLICY#: <u>6A SPX 38888-00</u>
INSURED REPRESENTATIVE U.S. Soccer	NAME: <u>Melissa Biniewicz</u> PHONE: (<u>312</u>) <u>528-1228</u> TITLE: <u>Development Academy Operations Manager</u> SIGNATURE: _____ DATE: _____

COMPLETE ALL SECTIONS AND EMAIL OR FAX TO:
U.S. Soccer • Attention: Melissa Biniewicz
email: mbiniewicz@ussoccer.org • Fax: (312) 808-1301



ACCIDENT MEDICAL INSURANCE CLAIM FORM



Policy Number: 6A SPX 38888-00

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED. OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

MEDICAL BENEFITS UNDER THIS POLICY PROVIDES EXCESS COVERAGE, PAYABLE WITH AN 80% CO-INSURANCE, FOR EXPENSES INCURRED WITHIN 52 WEEKS FROM THE INJURY DATE. THERE IS A \$1,000 DEDUCTIBLE WHICH CAN BE SATISFIED BY THE PAYMENTS MADE BY OTHER INSURANCE. IF THERE IS NO OTHER INSURANCE, THE FULL \$1,000 DEDUCTIBLE WILL APPLY. UPON RECEIPT OF THIS CLAIM FORM AND THE U.S. SOCCER INCIDENT REPORT, AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO AND ANY OTHER POLICY LIMITATIONS.

IF THE MEDICAL BENEFIT IS EXCESS, YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON: _____	SPOUSE'S NAME (if applicable): _____
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
EMPLOYER NAME: _____ <input type="checkbox"/> UNEMPLOYED	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: (_____) _____	PHONE: (_____) _____
GROUP INSURANCE COMPANY: _____	GROUP INSURANCE COMPANY: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COMPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
SOCIAL SECURITY NUMBER: _____	SOCIAL SECURITY NUMBER: _____
SIGNATURE: _____	SIGNATURE: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian.