



1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO HSR

E-Mail: soccerclaims@hsri.com

HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 Phone: (972) 512-5600 Fax: (972) 512-5820
 Toll Free (877) 477-2976

Policy Number: 9906-2983

AYSO Region #: _____

FOR HSR USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART I – POLICYHOLDER’S REPORT

1. Claimant’s Name (Injured Person)		2. AYSO Identification Number	3. Gender _M _F	4. Birthday _ / _ / _
5. Address of Injured Person		6. Best Contact Phone Number	7. E-Mail	
7. If Applicable, Parent’s Name, Address, and Best Contact Phone Number (Include Area Code)				
8. Date and Time of Accident		9. Place where Accident Occurred		10. Was the injured person a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer
Dental Claims Only	11. Indicate which Teeth were Involved in the Accident	12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
13. Nature of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)			Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident				
15. Did Accident Occur (Check Yes or No for Each of the Following):				
A. During an AYSO sponsored activity/event?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
B. While participating as a team member in a scheduled game, official tournament game, or practice session?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
C. While serving as an equipment manager, scorekeeper, trainer or volunteer worker?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
D. On activity premises?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
E. While traveling directly and uninterruptedly to or from home and policyholder premises?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Activity or Event		17. Name of Supervisor of Event or Activity		18. Was he/she a witness? <input type="checkbox"/> YES <input type="checkbox"/> NO
19. Name of Policyholder American Youth Soccer Organization		20. Address of Policyholder (Address, City, State, Zip) 12501 S. Isis Avenue, Hawthorne, CA 90250		
21. AYSO Regional Commissioner Signature X		22. AYSO Safety Director Signature X		DATE:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES NO

If Yes: Name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
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PART III - AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

FRAUD STATEMENTS

GENERAL: 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.

ALASKA, ARKANSAS, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

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.

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 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.

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 RESIDENTS: 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.

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.

MARYLAND: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

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 presents 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.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

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.

VIRGINIA: Any person who, with the 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 may have violated state law.

American Youth Soccer Organization (AYSO)

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully complete and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no and signing the line for authorization so that **HSR** and the doctors/hospitals may communicate concerning your claim.

Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.

2. The claim form must be signed by an AYSO Regional Commissioner and an AYSO Safety Director.
3. Only one claim form for each accident needs to be submitted.
4. Once completed, make a photocopy for your records and mail to the address shown below.
5. **DO NOT** assume that anyone else will mail this claim form to **HSR** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward their itemized bills to us.
2. If you have already been to the doctor/hospital and did not know about this coverage, please send all of the itemized bills you receive to **HSR** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for and the specific itemized charges incurred.
4. If this information is not on the bill when you send it to us, we will have to contact the doctor/hospital which will delay the review of your claim. “Balance Due” statements do not contain sufficient information to complete your claim. Mailing **HSR** “Balance Due” statements will only delay the processing of your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage, you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your other (primary) insurance has processed the claim.
3. We will require a copy of your primary insurance’s **Explanation of Benefits (EOB)**. This is the statement you receive from your primary insurance explaining what was paid or denied and the reason(s) why.
4. **HSR** will not be able to consider your claim without your primary insurance’s **Explanation of Benefits**.

If you have any questions, please contact AYSO NSTC at (800) 872-2976 or via e-mail at insurance@ayso.org.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007