



Insurance Claim Process

Coaches and Managers,

It is your responsibility to provide this information to your parents.

If a player injured in-season while participating in an FC Somers sanctioned event Medical Insurance and Secondary Insurance is available. Instructions to complete insurance claims can be found below and in the attached documentation.

Somers Youth Sports Organization (SYSO) - Medical and Secondary Insurance

Instructions:

- Parent completes form and attaches necessary documentation
- Parent brings form to President - FC Somers for signature
- Parent mails or faxes file to insurance carrier

See attached, SYSO - Accident Claim Form Procedures, for complete details.

Eastern New York Youth Soccer Association (ENYYSA) - Secondary Insurance, \$500 deductible.

Instructions:

- Coach completes form with assistance of Parent
- Coach mails or faxes to:

Lee D'Argenio
Registrar - WYSL
271 North Avenue; Suite #206
New Rochelle, NY 10801
Fax: (914) 235-5323

See attached, Advance Notice of Injury/Claim Form Procedure, for complete details.

Helen Brady,
President-FC Somers.

April 6, 2011

SYSO - ACCIDENT CLAIM FORM PROCEDURES

Each person filing a claim will need to submit a separate claim form.

All sections of the claim form must be completed in detail.

Please ensure that claim form is signed where indicated as no claims can be processed without the claim form being completed in its entirety.

The **SYSO Commissioner** for the participant's sport must also sign the form.

Medical Claims:

Balance due statements from the medical providers are not acceptable. Claimants must submit documentation on itemized insurance billing forms prepared by the medical provider or facility where treatment/services were rendered. A medical provider will provide a HCFA1500 Form and a facility (hospital) will provide a UB92 form.

For Excess Policies:

If you have primary medical coverage under another policy, you must submit a copy of the corresponding Explanation of Benefits statement from your primary insurance carrier in addition to the itemized insurance bills. Mail the claim form and the supporting documents to the claims office listed on the claim form.

Once your claim package is received, it will take approximately 10 – 15 business days to review and process. Please keep in mind that all decisions regarding claims will be made by the Claims Department and will be based on the documentation provided when the claim was filed.

If you have any questions/comments, please contact Customer Service Department at 800-551-0824, Monday through Friday, between the hours of 8am to 8pm EST.

National Union Fire Insurance Company of Pittsburgh, Pa. PROOF OF LOSS

AIG Domestic Claims Inc.
 A&H Claims Department
 P. O. Box 25987
 Shawnee Mission, KS 66225
 800-551-0824 (Toll Free)
 302-661-4176 (Direct)
 866-893-5984 (Fax)

NAME OF GROUP: Somers Youth Sports Organization
 c/o Town of Somers, Dept. of Rec.

POLICY NUMBER: **SRG-8063638**

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

- 1.) You must have **SECTION A** fully completed by a designated official of the Policyholder. (COMMISSIONER of PARTICIPANT'S SPORT)
- 2.) **SECTION B** is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
- 3.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. **PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/ - OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
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DATE COVERAGE BEGAN 4/30/09	DATE COVERAGE WILL END/HAS ENDED 4/30/10
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NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).
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NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	<input type="checkbox"/>	YES <input type="checkbox"/> NO
	B. DURING SPONSORED ACTIVITY	<input type="checkbox"/>	YES <input type="checkbox"/> NO
INDICATE THE SPORT (IF APPLICABLE)	C. DURING PROGRAMMED HOURS	<input type="checkbox"/>	YES <input type="checkbox"/> NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	<input type="checkbox"/>	YES <input type="checkbox"/> NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS
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POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER ()
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SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE
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SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #
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IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER
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NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE # ()
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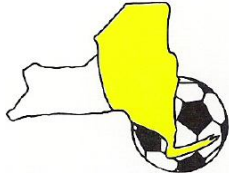
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

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, association, 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 the term of coverage of the Policy identified above 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.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO For claimants not residing in California, New York, or Pennsylvania: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE	DATE
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Eastern New York Youth Soccer Association, Inc.

Affiliated with ENYSASA – USYSA – USSF – FIFA



53 North Park Avenue, Suite 207, Rockville Centre, New York 11570-4111
516-766-0849 • 1-888-5-ENYISA • Fax 516-678-7411 • E-Mail enyoffice@enysoccer.com

Advance Notice of Injury/Claim Form Procedure

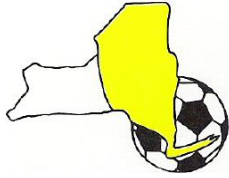
When reporting an injury the following procedure is taken:

1. The Advance Notice of Injury form must be completed by the Coach and submitted to your League.

Note: You have 90 days from date of injury to submit the claim form. For claims to be eligible for coverage you must seek medical attention within 60 days from the date of injury.
2. The League then verifies that the player is registered and that the injury occurred at a sanctioned ENYISA event. Once verified, the League approves and forwards to the ENYISA State Office.
3. ENYISA receives the Advance Notice of Injury form from the League, reviews and approves. The Claim Form is forwarded to the parent / guardian via e-mail. It is important that you include a current e-mail address on the form.
4. The parent / guardian must complete the Claim Form and return to the ENYISA State Office for processing. **If the Claim Form is not returned a claim will not be filed with the Insurance carrier.**
5. ENYISA forwards the Claim Form to the Insurance carrier.
6. At this point, inquiries should be directed toward the insurance carrier at 1-800-526-1379.
7. When submitting bills to our insurance carrier, please ensure the following:
 - Hospital bills must have a UB04 form
 - All other bills must have a HCFA1600 form

Note: ENYISA insurance is secondary insurance with a \$500 (five hundred dollar) deductible per occurrence.





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53 North Park Avenue, Suite 207, Rockville Centre, New York 11570-4111

516-766-0849 • 1-888-5-ENYUSA • Fax 516-678-7411 • E-Mail enyoffice@enysoccer.com

ADVANCE NOTICE OF INJURY

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ EMAIL: _____

CLUB: _____ TEAM: _____

DATE OF INJURY: _____ TIME: _____ PLACE: _____

EVENT: _____ (who was opponent)

TYPE OF INJURY: _____

HOW DID INJURY OCCUR? _____

DOES THE INJURED PLAYER HAVE PRIMARY INSURANCE? _____ YES _____ NO

COACH: _____ PHONE #: _____

SIGNATURE OF COACH: _____ DATE: _____

AFTER COMPLETING THE ABOVE, PLEASE SEND THIS FORM TO YOUR LEAGUE OFFICE.

LEAGUE APPROVAL _____ DATE: _____

8/21/09



1-800-934-3876 SOCCER.COM