Illinois State Soccer Association

Member of the United States Soccer Federation, Inc.

Illinois State
Soccer Association
2001 S. Halsted Street
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Chicago, IL 60608
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Secretary

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Hector Nava
Financial Secretary

Minos Vlamakis
Delegate-at-Large

Filip Cejovic
Delegate-at-Large

Alfonso Mitchell
Delegate-at-Large

Aleks Mihailovic
Director of Coaching Instruction

Judith McLean
Administrator & Registrar

Insurance Claim Instructions

Please complete the attached form, collect all the information from the check list below and submit everything to the ISSA office. You have **90 days** from the date of the accident to submit the claim.

Por favor complete los formularios, reúna la información solicitada en la lista de requisitos y envíela a la oficina de la ISSA. Usted tiene **90 días** de la fecha del accidente para someter la forma. ***Formas en español están disponibles en nuestra oficina al llamar al número 312-22-7920 o*** www.illinoissoccer.org

Informacja O ubezpieczeniu: Promisy o wypelnienie dolaczonej formy, zebranie wszystkich informacji I dostarczenie ich do biura ISSA.

Illinois State Soccer Association
2001 S Halsted St. suite 100
Chicago, IL 60608

For any injury questions or concerns, call NovaCare's Injury Hotline at 866-TRY-Nova (866-879-6682). An athletic trainer will return your call within 24 hours.
Visit www.novacare.com/chicagoland.htm for more information about NovaCare.

Si tiene preguntas acerca de una lesión llame al teléfono de NovaCare al 866-TRY-NOVA (866-879-6682) y un entrenador le devolverá la llamada en menos de 24 horas. Para más información acerca de NovaCare visite la página de internet www.novacare.com/chicagoland.htm

Insurance Check List

- Please make sure that you include the following with your insurance claim:
- Managers report (detailing events surrounding injury)
- Referee report (confirming Managers report)
- Copy of the line-up sheet
- Copy of player pass
- **Itemized bill HCFA or UB92 (balance due statements are not acceptable)**
- **If you have no other insurance we require written verification from your employer and or spouse's employer (if applicable)**

Lista de Requisitos Para el Seguro

- Por favor, asegúrese de que dispone d los siguientes documentos:
- Informe del Entrenador del equipo (detallando lo sucedido)
- Informe del Arbitro (confirmando el informe del Entrenador y lo sucedido)
- Copia de la alineación del partido
- Copia del carnet/pase del jugador
- **Lista detallada del cobro HCFA o UB92 (cobros que digan balance due no serán aceptados)**
- **Carta por escrito de su trabajo o el de su esposa/o (si está casado/a) de que no tiene seguro medico**

Lista Wymaganych Dokumento

Prosze dostarczyc wsystkie ponizej wymienione dokumenty:

- Raport Menadzera (dokladnie opisujacy powstanie urazu)
- Raport Sedziego Zawodow (zgodny z raportem menadzera)
- Kopie Protokolu Zawodow

Signature of State verification officer | Date

CLAIM PROCEDURE: U.S.A.S.A. SPECIAL RISK ACCIDENT CLAIM FORM - Please print or type

1. Participant (or legal guardian if under the age of 18) must complete this form in its entirety or it may be returned to you by the U.S.A.S.A. State Association.
2. **Do not delay submitting this claim form.** This form must be received, with or without attachments, within 90 days from the date of the accident, or benefits may be denied due to untimely filing.
3. Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your U.S.A.S.A. State Association office for validating.
4. Once the U.S.A.S.A. State Association has validated your claim, they will forward it to the insurance company for processing. The insurance company will inform you of any additional information they may need to process your claim.

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. **MAIL TO: State Vertification Officer Below**
Illinois State Soccer Association
2001 S Halsted St., suite 100
Chicago, IL 60608

National Union Fire Insurance Co. of Pittsburgh, Pa.

IF PARTS A and B ARE NOT COMPLETED IN FULL, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED

PART A - This section MUST be completed, dated and signed by the Injured Person - or by his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.

1. Name of Injured Person (insured): *First/Middle/Last*	1a. Date of Accident: *Mo/Day/Year*
2. Complete Mailing Address: *Street/City/State/Zip*	
3. Area Code/Home Ph#:	3a. Area Code/Work Ph#:
4. Player Social Security # (REQUIRED): NOTE: If Non-US Citizen without SS#, please check here: ☐	5. Date of Birth: *Mo/Day/Year*
6. ☐ Male ☐ Female	6a. ☐ Single ☐ Married ☐ Full-time Student

7. Are you currently enrolled in any health insurance and/or soccer accident plan?.. ☐ Yes ☐ No

If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.

Company Name: ________________________ Group Name: ____________________ Policy Number: ___________

Company Name: ________________________ Group Name: ____________________ Policy Number: ___________

7a.If you are not enrolled in any health insurance plan, we require written verification from your employer and your spouse's employer (if applicable), or Bursar's office if you are a full-time college student.
7b. If you are self-employed or unemployed and not covered under any health insurance plan, please sign below.

Signature of Player: ____

PART B - This section MUST be completed then signed by an official of your local organization.

1. Team name:	
2. League name:	
3. State Association:	3. a. Region:
4. Injury occurred at: ☐ Event ☐ Practice ☐ Travel ☐ Game	
4.a. Name of event:	
4.b. Injury occurred on: ☐ Indoor Field ☐ Outdoor Field	
5. Describe how accident occurred:	
6. Type of injury:	
7. Name and Phone Number of coach, manager or referee present at the time of the accident:	
8. Signature of witness:	Title:

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize The National Union Fire Insurance Company of PA 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 herby authorize any hospital, physician or other person who has attended me and my insurance carrier or employer to furnish to The National Union Fire Insurance Company of PA or its representatives any an all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, 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.

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.

For residents of New York: 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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

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.

(The above paragraphs are being used in order to facilitate our obtaining and providing proper information needed to quickly process your claim.)

______________________________ ________________________

Signature of Player Date

NOTE TO VERIFICATION OFFICER: Mail to:
AIG Domestic Claims
Attn: USASA Claims Unit Policy#9101928
A&H Claim Department
PO Box 25987
Shawnee Mission, Ks 66225
Email: A&H.claimssubmissions@chartisinsurance.com
Fax: 866 893 8574

AFTER you receive your Acknowledgement Letter, you may contact Myriam Nunez at (913) 495-4994 – (toll free) 800-551-0824 ext 4994 if you have any questions about your claim.

UNITED STATES ADULT SOCCER ASSOCIATION, ITS AFFILIATES, LEAGUES AND MEMBER TEAMS
PLAN LIMITATIONS & EXCLUSIONS – 2010– 2011

This statement is intended as a general description of excess, or secondary plan benefits available under the Participant Accident Policy. Please contact your state verification officer for further details.

All eligible expenses are subject to a $400 deductible.

SCHEDULED BENEFITS

Hospital Room & Board Expense (In-Patient)	$300, maximum per day
Hospital Miscellaneous (In-Patient)	$2,000, maximum per admission
Hospital Miscellaneous Expense (Out-Patient)	$500 maximum per admission
Hospital Emergency Care	$500, maximum per injury
Physician Expense (Non-Surgical)	$50, maximum per visit, limit 10 visits per injury
Surgeon Expense (In-or-Out-Patient)	Allowed at 50% of the Primary Insurer's negotiated rate for Surgeon's Expense where coverage is excess or 50% of Usual, Reasonable & Customary (URC) amount where coverage is primary (in no event will benefits exceed Insured's out of pocket expenses).
Assistant Surgeon Expense	Allowed at 25% of the Primary Insurer's negotiated rate for Assistant Surgeon's Expense where coverage is excess or 50% of Usual, Reasonable & Customary (URC) amount where coverage is primary (in no event will benefits exceed Insured's out of pocket expenses).
Anesthesiologist's Expense	Allowed at 25% of the Primary Insurer's negotiated rate for Anesthesiologist's Expense where coverage is excess or 50% of Usual, Reasonable & Customary (URC) amount where coverage is primary (in no event will benefits exceed Insured's out of pocket expenses).
Physical therapy or Chiropractic expense	$25 maximum per visit, limit 15 visits per injury
X-rays (In-or-Out-Patient) including diagnostic imaging, MRI, CAT scans, or similar procedures	$500 maximum per injury
Dental Expense (sound/natural teeth only)	$1,000, maximum per injury
Ambulance Expense	$150, maximum per injury
Orthopedic appliances or braces as a result of covered injury NOT for the prevention of injury.	$400, maximum per injury
Accidental Death and Dismemberment	$10,000

EXCLUSIONS

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or autoeroticism.
2. sickness, or disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any either of these.
3. the Insured's commission of or attempt to commit a felony crime.
4. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
5. declared or undeclared war, or any act of declared or undeclared war, except if specifically provided by this Policy.
6. participation in any team sport or any other athletic activity, except participation in a Covered Activity.
7. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded) (Loss caused while on short-tem National Guard or reserve duty for regularly scheduled training purposes is not excluded).
8. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured is:
    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passenger; or
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or the Insured's employer.
9. the Insured being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.
10. the Insured being under the influence of drugs unless taken under the advice of and as specified by a Physician.
11. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.
12. stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm.
13. any condition for which the Insured is entitled to benefits under any Workers' Compensation Act or similar law.
14. the Insured riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.
15. any loss incurred while outside the United States, its Territories or Canada.

PLAN MAXIMUM

$10,000 Accident Medical Expense Benefit payable per injury subject to plan limits. Coverage ends 104 weeks from the date of the accident.
Note: All members of Massachusetts leagues are not eligible for this plan and are excluded from the policy.

This document provides only a brief description of the coverage(s) available under policy series C11695DBG. The Policy may contain reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there are any conflicts between the contents of this document and the Policy, the Policy will govern in all cases. Insurance is underwritten by National Union Fire Insurance Company of Pittsburgh, PA, with its principal place of business in New York, NY. Not all coverages are available in every state. National Union Fire Insurance Company of Pittsburgh PA, is a Chartis company.