CLAIM INSTRUCTIONS

Cal South Youth Soccer Accident Insurance (NSAI)

These Instructions are to be used for completing the **SAI CLAIM FORM** for injuries occurring at Cal South sanctioned events STARTING September 1, 2013-August 31, 2014.

****Note: The claim form AS FOLLOWS should be submitted to AIG Accident & Health Claims Dept. as soon as possible after the injury occurs and not later than 30 days after first incurred treatment. Once any other primary carrier has paid, send a copy of the itemized bill and primary carrier Explanation of Benefits "EOB" to AIG for additional benefit consideration. It is suggested to keep copies of everything sent to AIG.**

General Information
There is a 52 Week Benefit Period starting September 1, 2013 – August 31, 2014. Injuries must be sustained during that time period. **First incurred treatment for injuries must be incurred within 90 days of the injury. The claim form must be received by AIG within 30 days of the first incurred treatment expense.**

Policies with Excess Coverage
Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all **EOB's (explanation of benefits)** from the primary insurance. If no primary coverage exists, the **SAI** coverage will act as a primary insurance subject to all policy terms and conditions.

Claim Form
The claim form must be submitted for each individual claim. **Section A** must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. **Section B** must be completed in full and signed by all parties shown. **Section C** must be completed in full and signed by all parties shown. **A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.**

Deductible ($1,000) + 20% Coinsurance
Each claim is subject to the $1,000 deductible and 20% Coinsurance. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

Medical Bills
Notify all medical providers – hospitals and doctors – if you will be using this insurance alone or along with your primary insurance. Provide them with the name and mailing address to AIG (provided below) and request that they submit the required insurance billing forms there. A physician's office should submit a CMS 1500. A hospital and/or emergency room should submit a UB04. **A balance due statement is not acceptable and will only delay processing.**

Information Requests
In the event that a claim is not submitted in full or if additional information is needed, the claim will be suspended, and the additional information will be requested via US Mail. Please forward the requested information immediately to AIG Accident & Health Claims Dept. to prevent delay in the adjudication of your claim.

Claim Submission Checklist – Use the below checklist to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary insurance, **if available**?	
If claim was first submitted to the primary, are copies of the EOB's (explanation of benefits) **if available**, attached?	
Have you requested itemized medical bills - CMS1500 or UB04 - to be **sent directly to AIG Accident & Health Claims Dept.?** **Address: P.O. Box 25987, Shawnee Mission, KS 66225-5987**	
Have **Parts A & Parts B** of the Claim Form been completed in its entirety?	
Has **Part C** of the Claim Form been completed and signed by all the appropriate Officials?	

Mailing the Claim Forms & Documents

When completed, **claimant** should mail the claim form including itemized medical bills (if not mailed directly to AIG by the medical providers) and copies of EOB's (explanation of benefits from primary insurance) to:

AIG Accident & Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987

******We recommend keeping copies of all documents as submitted in the event of a question during the claims process. ******

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the AIG claims office at **(800) 551-0824**.

CAL SOUTH YOUTH SOCCER

Registered Soccer Accident Insurance Claim Form

Group Name: California State Soccer Association – South

Policy # 9137627-A Effective-09/1/2013 – 8/31/2014

SECTION A – GENERAL INFORMATION (MUST BE COMPLETED IN FULL)

NAME OF PERSON COMPLETING FORM FOR MINORS: (Print Name Below) **You are the (Check one):** Parent • Guardian •

INJURED PERSON NAME : **Last, First, M.I.** **DOB** / / **Male • Female •** **SSN/VISA/GREEN CARD** / /

ADDRESS (Street Address, PO Box, City, State, Zip Code)

EMAIL ADDRESS/ PHONE NUMBER

NATURE OF INJURY (Describe How Injury Occurred and Body Part Injured)

DESCRIBE **WHERE** ACCIDENT OCCURRED: **Practice • Game • Tournament • Camp/Clinic • "Friendly" •**

Field Name/Loc: _____

DATE of INJURY: / /

Tournament Name/Loc:_____

At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes • No •

Name of Supervisor of Activity:

Was he/she a witness to the injury? Yes • No •

SECTION B – PRIMARY INSURANCE (MUST BE COMPLETED IN FULL AND SIGNED BY ALL PARTIES)

Is the Injured Person covered under any other health and/or accident insurance plans? **Yes • No •** If **YES,** give all of the following information:

Name of Other Insurance Company: **Address:** **Policy #:** **Name of Policyholder:**

Employer Name **(Street)** **(City)** **(State)** **(Zip)**

Area Code/Employer Telephone No. ( )

Name of Father or Male Guardian: **SSN/VISA/GREEEN CARD #:**
Place of Employment: **Address of Employer (If Different than above):**
Phone # of Employer: ( )

Name of Mother or Female Guardian: **SSN/VISA/GREEEN CARD #:**
Place of Employment: **Address of Employer (If Different than above):**
Phone # of Employer: ( )

SECTION C – AFFILIATE MEMBER VERIFICATION (TO BE COMPLETED BY CAL SOUTH CLUB/LEAGUE COACH & PRESIDENT)

AFFILIATE MEMBER ID (3 digits) **#:** _____ **PLAYER ID#:** **PLAY TYPE: Competitive • Camp/Clinic • Recreational/Signature •**

AFFILIATE CLUB/LEAGUE NAME:

We do hereby authorize that the claimant is a properly registered player with Cal South and that the injury was sustained during a Cal South sanctioned event.

Cal South Coach of Injured Claimant Signature & Date:	**Cal South Affiliate Member President Signature & Date:**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

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.

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 agenc 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

X Signature of Claimant or Authorized Representative of Claimant	**Date**

Remit Completed Form To: AIG Accident & Health Claims Dept. P.O. Box 25987 Shawnee Mission, KS 66225-5987
Phone: (800) 551-0824 Fax: (866) 893-8574 Email:A&Hclaimssubmissions@aig.com