

COMPLETE AND RETURN THIS FORM TO:



P.O. Box 390 Short Hills, NJ 07078

Medical/Dental Accident CLAIM FORM



# TEAM

52 week benefit period (required)

90/10 co-insurance

## SECTION I

TO BE COMPLETED BY PARENT/CLAIMANT

1. NAME: (first) \_\_\_\_\_ (last) \_\_\_\_\_

2. ADDRESS: \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code) \_\_\_\_\_

3. TELEPHONE #: \_\_\_\_\_ SS#: \_\_\_\_\_

4. BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ SEX:  Male  Female FASTPITCH  SLOWPITCH

5. CLAIMANT IS:  Youth  Coach/Manager  Other \_\_\_\_\_

6. NAME OF TEAM: Big Apple SB LG

7. NAME OF LEAGUE: \_\_\_\_\_

8. ACCIDENT INSURANCE ID#: \_\_\_\_\_

9. ACCIDENT DATE: \_\_\_/\_\_\_/\_\_\_ ACCIDENT TIME: \_\_\_\_\_  am  pm

10. BODY PART INJURED: \_\_\_\_\_

11. ACCIDENT OCCURRED DURING:  Game  Practice  Tournament  Camp/Clinic  Other \_\_\_\_\_

12. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: \_\_\_\_\_

13. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: \_\_\_\_\_

**\*\*IF THIS SECTION IS NOT FILLED OUT, BOLLINGER CANNOT PROCESS AND WILL RETURN CLAIM FORM\*\***

## SECTION II

### VERIFICATION

(Must be signed by Team/League Official)

I CERTIFY THAT THE ABOVE NAMED CLAIMANT IS AN INSURED MEMBER OF THE TEAM NAMED ABOVE AND THAT THE INJURY OCCURRED DURING OFFICIAL TEAM ACTIVITIES AS STATED.

NAME OF TEAM/LEAGUE OFFICIAL: \_\_\_\_\_ TITLE: \_\_\_\_\_

SIGNATURE OF TEAM/LEAGUE OFFICIAL: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE: \_\_\_\_\_

## SECTION III

### VERIFICATION (Must be signed by ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner)

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS ON A REGISTERED TEAM WITH THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF COMMISSIONER: \_\_\_\_\_ TITLE: \_\_\_\_\_

SIGNATURE OF COMMISSIONER: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE: \_\_\_\_\_

Was this injury a result of an ASA event? [ ] YES [ ] NO If no, indicate name of Organization that held event: \_\_\_\_\_

**SECTION IV****STATEMENT OF OTHER INSURANCE****(Required)****Father/Claimant**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_  
 STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 SELF EMPLOYED  UNEMPLOYED   
 EMAIL: \_\_\_\_\_

**Mother/Claimant**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_  
 STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 SELF EMPLOYED  UNEMPLOYED   
 EMAIL: \_\_\_\_\_

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND/OR DENTAL INSURANCE POLICY?  YES  NO  
 IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID?  YES  NO

INSURED NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ INSURED GROUP# /NAME: \_\_\_\_\_  
 INSURANCE COMPANY NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

**\*\*Please include a copy of insurance card (both sides)**

NOTE: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: \_\_\_\_\_

**SECTION V****ASSIGNMENT OF BENEFITS**

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

**SECTION VI****STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION****(Required)**

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantive civil penalty to the extent allows by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/CLAIMANT (required): \_\_\_\_\_ DATE: \_\_\_\_\_

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT/CLAIMANT (required): \_\_\_\_\_ DATE: \_\_\_\_\_

## HOW TO FILE A CLAIM: INSTRUCTIONS

### IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc.) in order for this policy to consider your expenses for payment. Payment under this policy will be made according to **usual and customary guidelines**. This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **90 days** from date of injury to submit claim form.  
For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.

**Benefit Period:** This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**

- a) Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
- b) Attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
- c) **Itemized bills are required:** You must submit itemized bills; balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicated that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

- HCFA-1500 is the standard form used by Providers, such as doctors and dentists, to show the medical treatments and charges made for each service.
- UB-04 or UB-92 is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.

5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.

- a) **Employer contribution to flex account** – Send to Primary insurance first, then flex account, then Bollinger.
- b) **Employee contribution to flex account** – Send to Primary insurance first, then Bollinger, then flex account. If monies have been paid out of your flex account before Bollinger, then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

**For further information contact:**

Bollinger, Inc.  
Sports Claims Department  
PO Box 390  
Short Hills, NJ 07078-0390  
Phone: 1-866-267-0093  
Fax: Attn. Sports Claims 973-921-2876  
[www.BollingerInsurance.com](http://www.BollingerInsurance.com)  
[www.BollingerASA.com](http://www.BollingerASA.com)

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