Pullen Insurance Services, Inc.

6300 Ridglea Place, Suite 614
Fort Worth, Texas 76116
(817) 738-6100 λ Fax: (817) 738-2993

(NOTE: Claim Form must be fully completed and signed.)

Basic Procedures for Submitting a Youth Soccer Accident Claim Form

1. Complete **ALL** questions on the Youth Soccer Accident Claim Form.

2. Have the coach or another local official that witnessed the accident sign **SECTION III** (COACH OR LOCAL OFFICIAL VERIFICATION.)

3. Sign the claim form in **SECTION VI** (STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION.)

4. File this new report of claim within 30 days of the date of accident or as soon thereafter as is reasonably possible.

5. If you have other insurance, submit your itemized bills to the other carrier first. You will receive a payment Explanation of Benefit worksheet (EOB) from your other carrier. Do **NOT** wait until your other carrier has processed all your bills before filing a Youth Soccer Accident Claim Form.

6. You may attach itemized bills and your other carrier's EOBs that are ready at the time of submitting this Claim Form.

7. ***Send Claim Form to your State Association for verification and signature.***

8. Upon receipt of the claim form from your state association we will forward an acknowledgement form advising you of receipt of your claim. All future correspondence concerning your claim should be directed to K&K at the address and phone number listed on your acknowledgement.

9. See back page for **Frequently Asked Questions**.

North Texas State Soccer Association
1740 S I-35, Suite 105
Carrollton, TX 75006

Coverage Underwritten by
Nationwide Mutual Insurance Company

Pullen Insurance Services, Inc.
6300 Ridglea Place, Suite 614
Fort Worth, Texas 76116
(817) 738-6100
Facsimile (817) 738-2993

POLICY #: 6B RPG 00000014659 00

IMPORTANT

THIS CLAIM FORM MUST BE MAILED TO YOUR STATE ASSOCIATION LISTED BELOW:

North Texas State Soccer Association
1740 S I-35, Suite 105
Carrollton, TX 75006

Policy Year: 9/1/05-9/1/06

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT, OR GUARDIAN

1. NAME:(last)_____(first)_____ (int.)_____
2. SOCIAL SECURITY NUMBER: _____ 3. BIRTHDATE: ____/____/____ 4. SEX: ☐ male ☐ female
5. HOME ADDRESS: (street)_____
   (city)_____(state)_____(zip code)_____
6. TYPE OF CLAIMANT: Player ☐ Coach/Asst.Coach ☐ Other ☐ _____ 7. ACCIDENT DATE: _____/_____/_____
8. DESCRIPTION OF INJURY (Indicate LEFT or RIGHT; i.e. Left Leg): _____
9. DID ACCIDENT OCCUR DURING: (√ all that apply) game ☐ practice ☐ tournament ☐ indoor soccer ☐
   sanctioned/sponsored activities ☐ travel directly and uninterruptedly to or from activity premises ☐
10. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: _____
11. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: _____

SECTION II STATISTICAL INFORMATION

1. NAME OF LOCAL ASSOCIATION OR LEAGUE: _____
2. NAME OF CLUB (if applicable): _____ 3. NAME OF TEAM: _____
4. AGE DIVISION: (U-12, U-10, etc.): _____ 5. COMPETITIVE: ☐ RECREATIONAL: ☐

6. **TIME:**	☐ MORNING	☐ AFTERNOON	☐ EVENING	☐ AFTER HOURS
7. **LOCATION:**	☐ ON FIELD	☐ SIDELINES	☐ SPECTATOR AREA	☐ OTHER
8. **DISPOSITION:**	☐ ON-SITE CARE ONLY	☐ AMBULANCE	☐ PERSONAL TRANSPORTATION	☐ REFUSED CARE
9. **SURFACE:**	☐ DIRT	☐ GRASS	☐ ARTIFICIAL TURF	☐ OTHER (Please list)
10. **SURFACE CONDITION:**	☐ DRY	☐ WET	☐ ICY	☐ IRREGULAR
11. **POSITION:**	☐ GOALIE	☐ FORWARD	☐ DEFENDER	☐ OTHER (Please list)
12. **ACTIVITY:**	☐ RUNNING W/BALL	☐ RUNNING W/O BALL	☐ DEFENDING	☐ OTHER (Please list)
13. **SITUATION:**	☐ HIT BY BALL	☐ COLLISION W/PARTICIPANT	☐ NON-CONTACT INJURY	☐ OTHER (Please list)

SECTION III COACH OR LOCAL OFFICIAL VERIFICATION

_____ _____ _____
Signature of Coach or Local Official | Coach or Local Official Name (print) | Date

SECTION IV **** TO BE COMPLETED BY AUTHORIZED STATE OFFICIAL ****

I, _____, of the _____ certify that the above claimant was a registered player, coach, asst. coach, or participant at the time the accident occurred.

_____ _____ _____
Signature of Authorized State Official | Title | Date

PULLEN INSURANCE SERVICES, INC. 6300 RIDGLEA PLACE, SUITE 614, FORT WORTH, TEXAS 76116 (817) 738-6100

CLAIMANT'S NAME: _____

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

SECTION V PARENT / GUARDIAN / CLAIMANT INFORMATION

FATHER / GUARDIAN / CLAIMANT

NAME: _____
S.S.#: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: (_____)_____
EMPLOYER: _____
PHONE: (_____)_____Ext_____
EMAIL: _____

MOTHER / GUARDIAN / CLAIMANT

NAME: _____
S.S.#: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: (_____)_____
EMPLOYER: _____
PHONE: (_____)_____Ext_____
EMAIL: _____

IS CLAIMANT COVERED UNDER ANY OTHER INSURANCE POLICY? YES ☐ NO ☐

COMPANY NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____
INSURED NAME: _____
INSURED ID#: _____ INSURED GROUP # / NAME: _____

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 VI STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION

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 substantial civil penalty where and to the extent allowed by state law.

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 Nationwide Mutual Insurance Company or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT: _____ DATE: _____

SECTION VII ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

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THINGS TO REMEMBER

1. **EACH STATE HAS A DEDUCTIBLE.** Check with your State Association to find out the amount of your deductible.

2. Each itemized bill MUST show the following:
   - Provider of Service's Name
   - Provider's Address
   - Provider's Federal Tax ID#
   - Provider's Telephone #
   - Date of Service
   - Diagnosis Description or Codes (ICD-9)
   - Procedure Description or Codes (CPT)
   - Charge for each Procedure

3. Additional bills to be submitted at a later date (after the initial submission of your claim) should be mailed directly to K&K, who is the claims payor for Nationwide Mutual Insurance Company, with the following information: Name of the claimant, date of the accident, and name of the State Youth Soccer Association.

4. Please allow time to properly process your claim.

5. Please respond promptly to any correspondence requesting additional information. It is the Parent / Guardian / Claimant's responsibility to request this information from the provider of service or from your primary carrier.

6. An Explanation of Benefits will be sent to you by K&K Insurance on behalf of Nationwide Mutual Insurance Company.

FREQUENTLY ASKED QUESTIONS

WHAT IS AN ITEMIZED BILL?

- An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

WHAT IF I DON'T HAVE AN ITEMIZED BILL?

- The Parent/Guardian must request this information from the provider of service. Some providers only mail a balance due statement. The claims payor, K&K is unable to process this charge without an itemized bill. Again, request this information from the provider service. Explain that you have Youth Soccer Excess Accident Coverage.

CAN YOU PROCESS THIS CLAIM WITH MY OTHER INSURANCE CARRIER'S WORKSHEET ALONE?

- No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

WHAT IF I DON'T HAVE MY OTHER CARRIER'S PAYMENT EXPLANATION (EOB)?

- The Parent/Guardian must request the EOB from their other insurance carrier.

• NORTH TEXAS STATE SOCCER ASSOCIATION •

ACCIDENT MEDICAL EXPENSE BENEFITS
and
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

TERM OF INSURANCE SEPTEMBER 1, 2005 TO SEPTEMBER 1, 2006

EXPLANATION OF COVERAGE

INSURED PERSONS

All registered team members, coaches, managers, officials, referees and volunteers of the teams, leagues or of the association.

COVERED ACTIVITIES

Insured persons are covered for injuries (or death) resulting directly and independently of all other causes, from accidents occurring while participating in the following covered activities:

- Scheduled games, team practice sessions or sponsored activities, provided they are under the direct supervision of a team official; or sanctioned local or national tournaments as a member of a contestant team.
- Organized, supervised group travel as authorized by the Policyholder directly to and from a covered event.

WHAT IS NOT COVERED

The plan does not provide coverage for: (1) intentionally self-inflicted injury; (2) air travel except as a fare-paying passenger on a regularly scheduled airline on a scheduled flight; (3) injuries resulting from other than Covered Activities; (4) loss resulting from sickness or disease, except bacterial infection which occurs through an accidental wound.

ACCIDENT MEDICAL EXPENSE BENEFITS

For reasonable necessary medical expenses, our Youth Soccer Medical Expense Insurance pays up to $100,000 for injuries sustained in a Covered Accident. Dental injuries are treated like any other injury. Payment will not be made for any expenses incurred after 104 weeks of the accident date. An Expense is considered incurred on the date the Medical Care is rendered. A $500 Deductible applies to each accident. Each claim is subject to the application of an 80/20 co-insurance provision.

"Injury" means bodily injury of an Insured Person resulting directly and independently of all other causes from an accident which occurs while he or she is participating in a Covered Activity. Sickness or disease (except pus forming infections which occur through an accidental cut or wound) of any kind will not be considered as bodily injury.

Reasonable Expenses means 100% of charges less the deductible and the co-insurance percentage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The plan pays:

- $5,000 for loss of life, or loss of two or more members, or
- $2,500 for loss of one member (hand, foot or eye), which results from injuries sustained in an accident which occurred while participating in a Covered Activity.
- Such payment shall be in addition to any other indemnity payable to the date of loss, but only one amount, the larger amount applicable shall be payable for all such losses resulting from any one accident.
- "LOSS" shall mean, with respect to hands and feet, physical separation through or above the wrist or ankle joint; with respect to the eyes, entire and irrecoverable loss of sight.

• NORTH TEXAS STATE SOCCER ASSOCIATION •

EXCESS COVERAGE

Accident Medical Expense insurance is provided on an "excess" basis. This means that after the insured player or coach has been reimbursed for medical expenses by other insurance programs, and after the deductible has been satisfied, the Youth Soccer Accident Medical Expense plan will pay up to the maximum Medical Expense benefit for remaining treatment, service and supply expenses. These other programs include group, blanket or franchise health insurance coverage, group hospital or medical service plans, and prepayment coverage; any coverage under labor-management trustee plans, union welfare plans, employer organization plans, and coverage under any governmental programs, coverage required or provided by any statute, and automobile reparations insurance (no-fault) coverage.

CLAIM PROCEDURES

For AD&D and Accident Medical Expense Claims, claim forms are available through your State Association, League or Club Offices. In the event of injury requiring medical treatment, you should:

- Fully complete a claim form verified by a witness and submit it to your State Soccer Association for verification.
- Notice of claims must be filed within 30 days from the date of injury.

Youth Soccer Accident Medical coverage is provided on an "excess" basis. Therefore, charges must first be submitted to any other medical insurance carrier available to the participant.

Detailed Accident Medical Expense claim instructions can be found on each claim form.

INDOOR SOCCER

The accident medical policy will provide the same benefits for indoor soccer as for outdoor soccer. For coverage to be valid your state association must recognize indoor soccer.

THIS OUTLINE IS ONLY FOR GENERAL INFORMATION AND NONE OF THE ABOVE SHALL AMEND OR ALTER THE INSURANCE CONTRACT. THE WORDING OF THE POLICY CONSTITUTES THE ONLY AGREEMENT BETWEEN THE INSURED AND THE INSURANCE COMPANY.

UNDERWRITTEN BY:

AN A.M. BEST RATED "A" INSURANCE COMPANY

NATIONAL ADMINISTRATOR:

PULLEN INSURANCE SERVICES, INC.

6300 Ridglea Place, Suite 614
Fort Worth, TX 76116
817-738-6100
FAX 817-738-2993
E-mail: ppullen@pullenins.com
Website: www.pullenins.com