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:**

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. Social Security #:	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:	3. a. Region:
4.IInjury 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