

UNITED STATES YOUTH VOLLEYBALL

ACCIDENT PROOF OF LOSS

SEE REVERSE SIDE FOR INSTRUCTIONS

COMPLETE AND RETURN THIS FORM TO:
 Bollinger Insurance – Sports Claims
 P. O. Box 390, Short Hills, NJ 07078-0390

TO BE COMPLETED BY CLAIMANT						
NAME OF CLAIMANT (Last Name)		(First Name) (Middle Initial)		SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS OF CLAIMANT (Street) (City) (State) (Zip code)			TELEPHONE NUMBER ()	OCCUPATION		
DATE & TIME OF ACCIDENT		NATURE OF INJURY			ACCIDENT DUE TO EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	

FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:

- A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT

- B. PLACE OF ACCIDENT (BE SPECIFIC)

- C. DESCRIBE HOW ACCIDENT HAPPENED

MEDICAL AUTHORIZATION	PAYMENT AUTHORIZATION
I hereby authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disability Please sign here _____ Claimant (if Adult) or Parent/Guardian please sign above Date _____	I hereby authorize payment of benefits directly to the providers rendering services. Please sign here _____ Claimant (if Adult) or Parent/Guardian please sign above Date _____

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED			
1. Name and Address of Claimant's Employer: (If a minor, complete # 2 & 3)			
2. Father's Name or Guardian:	Occupation:	Name and Address of His Employer:	Phone #:
3. Mother's Name or Guardian:	Occupation:	Name and Address of Her Employer:	Phone #:
4. Do you have a Group, Personal Healthcare or Medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of your Health Care Provider		Address	

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature _____ Date _____
 Claimant (if Adult) or Parent/Guardian

TO BE COMPLETED BY USYVL ADMINISTRATOR			
EFFECTIVE DATE OF COVERAGE 8/1/07	COVERAGE TERMINATION DATE, IF APPLICABLE 8/1/08	POLICY NUMBER 4102AH028573	NAME OF GROUP POLICYHOLDER USYVL
ADDRESS OF POLICYHOLDER (Street) (City) 2771 Plaza Del Amo, #808 Torrance		(State) CA	(Zip Code) 90503
TELEPHONE NUMBER ()			
IF ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SUPERVISED BY YOUR ORGANIZATION, DESCRIBE ACTIVITY, HOW ACCIDENT OCCURRED, AND SPECIFY DATE OF OCCURRENCE.			
REMARKS:			
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.		TITLE	DATE
AUTHORIZED SIGNATURE: _____			

IMPORTANT: Claims CANNOT Be Processed Unless All Information is Provided.

1. Accident medical expense coverage is provided on an EXCESS BASIS, and benefits will only be paid under this plan AFTER YOUR OWN PERSONAL OR GROUP INSURANCE (including Health Maintenance Organizations [HMO's]) HAS PAID OUT ITS BENEFITS. Please note that you must follow your primary insurance carrier's eligibility criteria in order for this policy to consider your expenses for payment. You must send copies of any and all payments (or denials) made by your insurance plan with the claim form.
2. The Statement of Other Insurance section must be fully completed. If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.
3. Please check and make sure that:
 - a) An Official or Administrator of the Policyholder has completed his/her section of the claim form.
 - b) You have completed and signed the Parent/Guardian or Insured's Statement of other Insurance.
 - c) The Medical Records Authorization **MUST** be signed and dated. If you want payments to be sent directly to your doctor or healthcare provider, sign the Payment Authorization Section.
 - d) You have attached all unpaid itemized bills to this form.
 - e) You have attached any Explanation of Benefits forms that you have received from your Primary insurance carrier or other healthcare plan.
 - f) You have completed the front of this form.
4. Subsequent bills should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new Claim Form is NOT necessary.**
5. **Flexible Spending Account:** You must submit your bills through your primary insurance carrier and Bollinger Insurance first before accessing your Flexible Spending Account within your company.
6. **Dental Bills:** All dental bills must be submitted through your primary insurance's **medical and dental** plans first before submitting the bills to Bollinger.
7. **Important Note:** This accident insurance provides benefits on a limited basis. Treatment for a covered injury under this policy must begin within **60 days** of the date of injury. This policy is subject to a **52-week benefit period**. This means only those medical or dental bills that are incurred within **52 weeks** (1 year) of the date of injury are eligible for coverage under this policy. Any expenses or treatments that take place after the **52-week** benefit period cannot be covered by this policy.
8. **Important Note:** Due to HIPAA Regulations, Bollinger is no longer accepting information via fax.

If you need further information, call Bollinger at 1-866-267-0093.

WHERE TO SEND THE COMPLETED FORM:

Bollinger Insurance, Inc.
Sports Claims Department
P. O. BOX 390
SHORT HILLS, NJ 07078-0390