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 **104 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 104 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **104 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 indicate 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 Claims information contact:
Bollinger Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 866-267-0093
Fax: 973-921-2876

Send this claim form for authorization to:
M.E. Wilson Co., Inc.
P.O. Box 373
Tampa, FL 33601
Phone: 813-229-8021
Fax: 813-229-2795

COMPLETE AND RETURN THIS FORM TO:

M.E. Wilson Co., Inc.
P.O. Box 373
Tampa, FL 33601

Deductible: $2,000 with 80/20 Coinsurance

104 Week Eligibility Period

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN (Required)

1. NAME: (first) ______ (last) ______ Phone: ______
2. ADDRESS: ______ (city) ______ (state) ______ (zip code) ______
3. BIRTHDATE: ______ SEX: ☐ MALE ☐ FEMALE
4. CLAIMANT IS A: ☐ PLAYER ☐ COACH ☐ OFFICIAL OTHER ______
   Team/Club Code: ______ Player/Pass #: ______
5. ACCIDENT DATE: ______ ACCIDENT TIME: ______
6. BODY PART INJURED: ______
7. ACCIDENT OCCURRED DURING: ☐ GAME ☐ PRACTICE ☐ TOURNAMENT ☐ CAMP/CLINIC
8. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:
   ______
9. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: ______

SECTION II STATISTICAL INFORMATION (Required)

1. NAME OF TEAM/CLUB: ______
2. TYPE: ☐ COMPETITIVE ☐ RECREATIONAL
3. LOCATION: ☐ ON FIELD ☐ INDOOR ☐ SPECTATOR AREA ☐ OTHER
4. SURFACE: ☐ DIRT ☐ GRASS ☐ OUTDOOR TURF ☐ INDOOR TURF
5. SURFACE CONDITION: ☐ DRY/NORMAL ☐ WET/RAINY ☐ ICY ☐ MUDDY
6. POSITION: ______
7. STATUS: ☐ HIT BY OBJECT ☐ COLLISION W/OPPONENT ☐ COLLISION W/TEAMMATE
   ☐ OTHER ______

SECTION III TO BE COMPLETED BY COACH & AFFILIATE AGENT OF RECORD (Required)

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER
6-1-2009	6-1-2010	4102AH0243046	Florida Youth Soccer

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	(Zip)	TELEPHONE NUMBER
7201 Lake Ellenor Drive, Suite 200	Orlando	FL	32809	407-852-6770

DESCRIBE FYSA SANCTIONED ACTIVITY OR TOURNAMENT IN WHICH INCIDENT OCCURRED INCLUDING NAME OF EVENT, HOW INCIDENT OCCURRED AND SPECIFIC LOCATION AND DATE OF OCCURRENCE.

______
______
______

☐ YES-SPONSORED/SANCTIONED ACTIVITY ☐ YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

COACH SIGNATURE: ______ TITLE: ______ DATE: ______

AGENT SIGNATURE: ______ TITLE: ______ DATE: ______

SECTION IV — STATEMENT OF OTHER INSURANCE (Required)

Father/Guardian/Claimant

NAME: ______________________

ADDRESS: ______________________

CITY: ______________________

STATE: __________ ZIP: __________

PHONE: ______________________

EMPLOYER: ______________________

PHONE: ______________________

SELF EMPLOYED ☐ UNEMPLOYED ☐

Mother/Guardian/Claimant

NAME: ______________________

ADDRESS: ______________________

CITY: ______________________

STATE: __________ ZIP: __________

PHONE: ______________________

EMPLOYER: ______________________

PHONE: ______________________

SELF EMPLOYED ☐ UNEMPLOYED ☐

If you are employed but have no insurance, you must include a letter of verification from your employer on their letterhead that no insurance is provided to you (or to your dependents, if this claim is for your child) through your workplace.

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 GRP#/NAME: __________

COMPANY NAME: ______________________

ADDRESS: ______________________

CITY: __________ STATE: __________ ZIP: __________

PHONE: ______________________

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

For services rendered or to be rendered I hereby authorize the Insurance Company or their representatives to pay benefits in connection with this accident or injury directly to the doctor, hospital or other provider of service. If paid receipts are submitted with this claim form, benefits will be paid to the insured.

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 substantial civil penalty to the extent allowed by state law.

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

SIGNATURE OF PARENT/GUARDIAN/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/GUARDIAN/CLAIMANT (Required): ______________________ **DATE:** __________