COMPLETE AND RETURN THIS FORM TO:

Bollinger Insurance Solutions

P.O. Box 390 Short Hills, NJ 07078

ACCIDENT PROOF OF LOSS/CLAIM FORM

ASA USA Softball
THE NATIONAL GOVERNING BODY OF SOFTBALL

UMPIRE

$100 Deductible **52 week benefit period**

SECTION I TO BE COMPLETED BY CLAIMANT (required)

1. **NAME:** (first) _____ (last)_____
2. **ADDRESS**: _____ (city) _____ (state) _____ (zip code)_____
3. **TELEPHONE #**:_____
4. **BIRTHDATE:** ___/___/___ **SEX:** ☐ Male ☐ Female
5. **FASTPITCH** ☐ **SLOWPITCH** ☐
6. **YOUTH** ☐ **HIGHSCHOOL** ☐ **COLLEGE** ☐
7. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ ☐ am ☐ pm
8. **BODY PART INJURED:**_____
9. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Other_____
10. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____

_____

_____

11. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**_____

SECTION II VERIFICATION (Must be signed by 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 A REGISTERED UMPIRE WITH THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF COMMISSIONER: _____ TITLE: _____

SIGNATURE OF COMMISSIONER: _____ DATE: _____

PHONE: _____

SECTION IV STATEMENT OF OTHER INSURANCE (required)

Claimant

NAME:_____

ADDRESS:_____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

EMPLOYER NAME:_____

EMPLOYER PHONE: _____

SELF EMPLOYED ☐ UNEMPLOYED ☐

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 GRP#/NAME:_____

COMPANY NAME:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

PHONE:_____

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

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 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 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 CLAIMANT (required): _____ DATE: _____

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

1. Accident medical expense coverage under this policy 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) 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.

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 Providers/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 will not be processed. See below for forms needed.

      1. HCFA-1500- standard form used by Providers
      2. UB-04 or UB-92-standard form used by Hospitals
      3. Payment of bills will follow the **usual and customary guidelines.** This means that the basis for payment of specific medical or dental claims 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.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Bollinger.

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-Primary insurance first, then flex account, then Bollinger
   b) Employee contribution to flex account-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: 1-866-267-0093
Fax: 973-921-2876

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Insurance Solutions