

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:
 Metropolitan D.C. - Virginia Soccer Association, Inc.
 2239-A Tacketts Mill Drive
 Woodbridge, Virginia 22192



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): <i>First /Middle/Last</i>	1a. Date of Accident: <i>Mo/Day/Year</i>
2. Complete Mailing Address: <i>Street/City/State/Zip</i>	
3. Area Code/Home Ph#:	3a. Area Code/Work Ph#:
4. Social Security #:	5. Date of Birth: <i>Mo/Day/Year</i>
6. <input type="checkbox"/> Male <input type="checkbox"/> Female	6a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Full-time Student
7. Are you currently enrolled in any health insurance and/or soccer accident plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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. Injury occurred at: <input type="checkbox"/> Event <input type="checkbox"/> Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game
3a. Name of event:
3b. Injury occurred on: <input type="checkbox"/> Indoor Field <input type="checkbox"/> Outdoor Field
4. Describe how accident occurred:
5. Type of injury:
6. Name and Phone Number of coach, manager or referee present at the time of the accident:
7. Signature of witness: _____ Title: _____

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize The Hartford Life Insurance Company 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 hereby authorize any hospital, physician or other person who has attended me, and my insurance carrier or employer, to furnish to The Hartford Life Insurance Company or its representatives any and 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.

(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: _____

CLAIMS ADMINISTRATION BY K&K INSURANCE GROUP c/o YOUR STATE ASSOCIATION VERIFICATION OFFICER

