

COMPLETE AND RETURN THIS FORM TO:

SILENT SPORTS ACCIDENT PROOF OF LOSS

McKay Insurance Agency
106 E. Main Street, P.O. Box 151
Knoxville, IA 50138

52-week benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

- 1. **NAME:** (first) _____ (last) _____
- 2. **ADDRESS:** _____ (city) _____ (state) _____ (zip code) _____
- 3. **TELEPHONE #:** _____
- 4. **BIRTHDATE:** ___/___/___ **SEX:** Male Female
- 5. **CLAIMANT IS A:** Player Coach Official Other
- 6. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ am pm
- 7. **BODY PART INJURED:** _____
- 8. **ACCIDENT OCCURRED DURING:** Game Practice Tournament Camp/Clinic Other _____
- 9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:** _____

- 10. **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 ORGANIZATION OR AUTHORIZED OFFICIAL (required)

POLICY EFFECTIVE DATE 10/15/2010	POLICY EXPIRATION DATE 10/15/2011	POLICY # SRG9106820	NAME OF POLICYHOLDER Silent Sports Association
ADDRESS OF POLICYHOLDER (Street) 106 E. Main Street, P.O. Box 151	(City) Knoxville	(State) IA	TELEPHONE NUMBER 800-942-0283

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT.

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

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

AUTHORIZED SIGNATURE:	TITLE:	DATE:
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SECTION IV

STATEMENT OF OTHER INSURANCE (required)

Claimant/Father

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

EMPLOYER: _____

PHONE: _____

SELF EMPLOYED _____ UNEMPLOYED _____

Claimant/Mother

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

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)**

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

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

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/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/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-Your Primary insurance first, then your flex account, then Bollinger
- b) Employee contribution to flex account-Your Primary insurance first, then Bollinger, then your 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

