CLAIMS FILING INSTRUCTIONS
FOR
USASA ACCIDENT POLICIES

DES CHAMPS & GREGORY, INC.
INSURORS

Note: This coverage is EXCESS of other insurance. Please be sure to submit other insurance information (if available) when requested.

1. You have been provided with a claim form that is designed specifically for USASA. Please use only this form. Do not delay submitting this form: it 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.

2. Part A must be fully completed and signed by the participant or his/her legal guardian.

3. The form must be approved and verified by the League and State Association Verification Officers then sent to USASA National Office, 7000 S. Harlem Ave., Bridgeview IL 60455. USASA's National Office will then send to K&K for Processing.

4. Submit itemized insurance billing forms.* These forms are available from your health care provider and include the patient's name, condition (diagnosis), type treatment and date the expenses(s) was/were incurred. "Balance due" statements are not acceptable.

5. If you have medical coverage under another policy you must submit the bills to your primary insurer first and submit a copy of your primary insurer's Explanation of Benefits statement (EOB) to K&K Insurance Group, Inc. /Specialty Benefits. IF YOU HAVE OTHER INSURANCE, YOUR CLAIM CANNOT BE PROCESSED BY K&K Insurance Group, Inc. / Specialty Benefits WITHOUT YOUR PRIMARY CARRIER'S EOB.

6. USASA National Office will email, fax or mail your COMPLETED FORM TO:

   US Adult Soccer Association
   Attn: Insurance Department
   7000 S. Harlem Avenue
   Bridgeview, IL 60455
   Email: insurance@usasa.com
   Fax: 708-496-6879

7. Once the completed form is received by K&K Insurance Group, Inc/Specialty Benefits you and your State Verification Officer and USASA National Office will receive a claims acknowledgement letter.

8. AFTER you receive your Acknowledgement Letter, you may contact K&K Insurance Group, Inc./Specialty Benefits at 800-237-2917 Option 1.

QUESTIONS AND ANSWERS ABOUT
THE PARTICIPANT ACCIDENT INSURANCE (PAI)
AND THE CLAIM FILING PROCESS

1. If I get injured playing soccer how do I file a claim?
To file a claim you need a claim form filled out completely and sent in to the State Association so they can verify that you are a registered player in an affiliated league in the state. You must use an updated USASA claim form.

2. What should I send with the claim form?
Try to send at least one bill so that it will start the process and be set up as a working claim. Of course you can always send the claim form in right away. Please double check and make sure the claim form is completely filled out and be sure to sign page 3 of the form.

3. Should I use my State Association as my insurance company for the medical providers I see such as the Doctor of hospital?
No! Your State Association is not the insurance company and if you send your bills are sent directly to the State Association it will delay payment of you bills. With the claim form try to send one bill and the State Association will forward it on to the administrator of the insurance for United States Adult Soccer Association who will in turn complete the process.

4. How soon after I send in the form and a bill should I expect to be contacted?
The Claim will be processed within 2 weeks of receipt by the insurance company after the State Association submits claim to the USASA office. Make sure you have followed the process and the claim form is complete.

5. What do I get as acknowledgement from the insurance company?
Within two weeks of the USASA claims administrator receiving the claim form, you will be sent an acknowledgement letter with a description of benefits. Once the person has received this information they then forward all bills directly to the claims administrator at the address provided. The best way to get things taken care of in a timely fashion is to deal directly with the claims administrator after you have a working claim established.

6. Who should I deal with about my claim?
If you have sent in the completed USASA claim form to your State Association so they can verify that you are a registered player; from that point forward you will deal directly with the claims administrator. You will receive correspondence from them instructing you where to send the remaining bills and an explanation of your benefits as well as names and numbers of people you can contact if you have questions or concerns about your claim and a claim number you can use as a reference when contacting them.

7. Is the soccer insurance secondary insurance?
Yes. So when you go to the hospital or doctor you should give your own insurance as the primary insurance and the soccer insurance as secondary insurance. If you do not have any other type of insurance then the soccer insurance does become your primary insurance.

8. Should I contact the insurance company right when I get injured?
No. There is no need to contact the insurance company until you establish a working claim. To establish a working claim you need to fill out an official claim form so the State Association can verify that you are a registered player. Your State Association then forwards the information on to the USASA office which in turn sends the claim on to the claims administrator who then starts a working claim. Part of that process includes contacting you with claim information, a benefit summary and a contact person and address so you can send further bills directly to the USASA claims administrator.

9. Do I need to contact my State Association about my claim?
No. Your State Association is not the insurance company and does not get information about your individual claim. It is best to contact the claims administrator after you have a working claim established for all your claim questions.

10. Is there a time limit to file a claim?
Yes. You have 90 days from the date of the accident to file a claim.

11. Where can I find a claim form?
If for some reason you cannot obtain a claim form from your league or the State Association you can download one from the USASA web page.

Other Helpful information:

Once the completed form is received by K&K Insurance Group, Inc/Specialty Benefits the injured player will be mailed a claims acknowledgement letter within 48 business hours.

After you have received the Acknowledgement Letter, you then may contact K&K Insurance Group, Inc./Specialty Benefits at 1-800-237-2917 Option 1.

K&K Insurance Group

Policy # 36SB204969

UNITED STATES ADULT SOCCER ASSOCIATION (USASA)

7000 S. Harlem Avenue
Bridgeview, IL 60455

DES CHAMPS & GREGORY, INC.
INSURORS

This statement is intended as a general description of excess plan benefits available under the Participant Accident Policy. Please contact your state verification officer for further details.

INSURED PERSON: Participants including players, coaches, referees, coaches/players for whom premium has been paid.

COVERED ACTIVITIES: This policy covers injury resulting from an accident which occurs during the sport coverage period for the insured person's team while he or she is participating as a member of a Team in a USASA affiliated sanctioned event (scheduled game, official tournament game, practice/tryout session); or traveling directly to or from a game or practice session as a member of a team.

ACCIDENT PLAN LIMITATIONS AND EXCLUSIONS – 2017-2018

Accident Medical Expense Benefit	$5,000 maximum benefit
(sound, natural teeth only)	$1,000 maximum dental limit
Deductible Amount	$400 of all eligible expenses
Accidental Death Benefit	$5,000 principal sum
Accidental Dismemberment Benefit	$5,000 principal sum
Hospital Room & Board Expense (In-Patient)	$300 maximum per day
Hospital Miscellaneous (In-Patient)	$1,000 maximum per admission
Hospital Miscellaneous Expense (Out-Patient)	$250 per admission
Hospital Emergency Care	$350 maximum per injury
Physician Expense (Non-surgical)	$35 maximum per visit limit, 10 visits per injury
Surgeon Expense (In-or-Out-Patient)	Allowed at 50% of Usual, Reasonable & Customary (UCR) amount
Assistant Surgeon Expense	Allowed at 25% of surgeon's UCR
Anesthesiologist	Allowed at 25% of surgeon's UCR
Physical Therapy or Chiropractic Expense	$25 maximum per visit, limit 15 visits per injury
X-rays (In-or-Out-Patient) including diagnostic Imaging, MRI, CAT Scans, or similar procedures	$150 maximum per injury
Ambulance Expense	$150 maximum per injury
Orthopedic appliances or braces as a result of covered Injury NOT for the prevention of injury	$400 maximum per injury

EXCLUSIONS

General Exclusions The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced.

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while: a.participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing; b.riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a Medically Necessary motorized wheelchair, unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.
5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is: a. employed or retained by the Policyholder, or its subsidiaries or affiliates; b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
5. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
6. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
7. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits.
8. Expenses Incurred for personal comfort or convenience items including, but not limited to, Hospital telephone charges, television rentals, or guest meals.
9. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
10. Expenses Incurred for supervision of an anesthetist.
11. Expenses Incurred for Durable Medical Equipment rental in excess of the purchase price.
12. Expenses Incurred for subsequent repairs and replacement of prosthetic devices and orthopedic braces and appliances.
13. Expenses Incurred for any condition covered by any Workers' Compensation Act, Occupational Disease law or similar law.

SPECIAL NOTICE: This is only a very general reference to what coverage(s) the insurance policy or policies provide and is not intended to attempt to describe all of the various details pertaining to the insurance policy. Actual coverage's are detailed in the policy and are always subject to all terms, provisions, conditions, and exclusions as contained therein. You should not rely upon this general summary, but should consult the actual policy language for a complete description and details regarding coverage.

Signature of State Association / Nationwide affiliate 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/Nationwide affiliate.
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. It must be completed in its entirety. Answer every section.
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/Nationwide affiliate office for validating.
4. Once the U.S.A.S.A. State Association/Nationwide affiliate has validated your claim, they will **forward it to USASA National Office** to preview and forward to the insurance company. The insurance company will inform you of any additional information they may need to process your claim.

K&K INSURANCE

SPECIALTY BENEFITS, INC.
an affiliate of K&K Insurance Group, Inc.

DES CHAMPS & GREGORY, INC.
INSURORS

1. **COMPLETE THIS FORM.**
2. **ATTACH ALL BILLS.**
3. **MAIL TO: State Verification/Nationwide affiliate officer below**

UNITED STATES ADULT SOCCER ASSOCIATION

U.S.A.S.A. SPECIAL RISK ACCIDENT CLAIM FORM

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): *First /Middle/Last*

1a. Date of Accident: *Mo/Day/Year*

2. Complete Mailing Address: *Street/City/State/Zip*

3. Area Code/Home Ph#:

3a. Area Code/Work Ph#:

3b. Email Address:

4. Is the injured person a Medicare/Medicaid beneficiary? ☐ Yes ☐ No

4a. If Yes, please provide Social Security number or Health I.D. number: _____

5. Date of Birth: *Mo/Day/Year*

6. ☐ Male ☐ Female

6a. ☐ Single ☐ Married ☐ Full-time Student

7. Are you currently enrolled in any health insurance and/or other soccer accident plan? ☐ Yes ☐ 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 in full, then signed by an official of your local organization.**

1. Team name:

1a. League name:

2. State Association/Nationwide affiliate: Georgia Adult

2a. Region: III

3. Injury occurred at: ☐ Game ☐ Practice ☐ Travel ☐ Other Event

4. Name and type of event:

4a. Injury occurred on: ☐ Indoor Field ☐ Outdoor Field

5. Describe how accident occurred *(example: tackled from behind, tripped and fell, collision with player, etc.)*:

6. Type of injury *(example: broken arm, sprained ankle, broken nose, etc.)*:

6a. Body part injured *(example: ankle, knee, shoulder, head, etc.)*:

7. Name and Phone Number of coach, manager or referee present at the time of the accident:

8. ***I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include prosecution.***

Signature of League Verification Officer: NO. Title:

Signature of USASA Verification Officer: NO. Title:

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc./Specialty Benefits 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 herby authorize any hospital, physician or other person who has attended me and my insurance carrier or employer to furnish to K&K Insurance Group, Inc./Specialty Benefits or its representatives any an 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.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: 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 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: 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 conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefit and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include prosecution.

Signature of Player: YES! Date:

Signature of Coach, Manager or Referee: Date:

AFTER you receive your acknowledgement letter, you may contact K&K Insurance Group, Inc./Specialty Benefits at 1-800-237-2917, Option 1, if you have any questions about your claim.

K&K Insurance Group, Inc./Specialty Benefits, Attn: PA Claims, P.O. Box 2338, Fort Wayne, IN 46801
Email: KK_PAClaims@kandkinsurance.com • Fax: 312-381-9077

The First Health Network HYGEIA PHCS