CLAIMS FILING INSTRUCTIONS FOR USASA ACCIDENT POLICIES

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 as a claim form must be received by A-G Administrators, with or without medical bills, within 12 months from the date of the accident or your claim may be denied for untimely filing.

2. Treatment must be initiated and covered expenses incurred within 90 days from the date of the accident. Evidence of this, medical bills or medical records, must accompany the claim to satisfy this provision of the policy.

3. Part A must be fully completed and signed by the participant or his/her legal guardian. The claim form must be approved and verified by the League and State Association Verification Officers and then sent to the National Office.

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

5. If you are covered under other insurance (i.e. employers group plan), give the medical providers involved in your care the other insurance (i.e. employers group plan) as your primary payer and the (USASA) insurance information as the secondary payer. If this is done, the medical provider will automatically bill A-G with the proper itemized bills and provide your Explanation of Benefits (EOB) form. If you were unable to give the medical providers this information before you are balanced billed, A-G will need copies of all itemized bills that show dates of service, diagnosis codes, procedure codes and your primary payer Explanation of Benefits (EOB) forms. If medical providers have the information from both insurance plans your claim will be processed in a more efficient manner.

6. After signed by League and State Association Verification Officers, Georgia Soccer send ~~Email, fax or mail your~~ COMPLETED CLAIM FORM TO:

United States Adult Soccer Association (USASA)
Attn: National Office/Insurance Department
7000 S. Harlem Avenue
Bridgeview, IL 60455
Email: insurance@usasa.com
Fax: 708-496-6879

Send completed form to:
Jade Beaulieu
Georgia Soccer
jade@georgiasoccer.org

7. USASA National Office will forward the completed claim form to A-G. You, your State Verification Officer and USASA National Office will receive a claims acknowledgement letter.

8. AFTER you receive your AcknowledgementLetter, you may contact A-G at 800-634-8628.

UNITED STATES ADULT SOCCER ASSOCIATION (USASA)

7000 S. Harlem Avenue
Bridgeview, IL 60455

This benefit summary is intended as a general description of the excess accident medical expense and accidental death and dismemberment benefits available under the insurance policy issued to USASA.
Please contact your Designated Organization Verification Officer

COVERED PERSONS: Players, coaches, referees, and coaches/players for whom premium has been paid.

COVERED ACTIVITIES: Coverage, subject to the terms, conditions, limitations and exclusions of the Policy, for injuries resulting from Covered Accidents which occur while the Covered Person is participating as a member of a Team in a USASA affiliated sanctioned event (scheduled game, official tournament game, practice/tryout session of the team); or while traveling directly to or from a game or practice session as a member of a team.

ACCIDENT PLAN BENEFITS, LIMITATIONS AND EXCLUSIONS - 2020

Benefit limits apply on a per Covered Person per Covered Accident basis.

Accident Medical Expense Benefit	$5,000 maximum benefit
Benefit Period	52 Weeks
Incurral of First Expense	Within 90 days of Covered Accident
Deductible Amount	$400
Hospital Room & Board Expense (In-Patient)	$300 maximum per day
Hospital Miscellaneous Services (In-Patient)	$1,000 maximum
Hospital Miscellaneous Services (Out-Patient)	$250 maximum
Ambulatory Medical Center (Out-Patient)	50% of Usual & Customary (U&C) amount
Emergency Room Treatment	$350 maximum
Physician Services (Non-surgical; In-or-Out-Patient)	$35 maximum per visit, for up to 10 visits
Surgery Benefit (In-or-Out-Patient)	50% of Usual & Customary (U&C) amount
Assistant Surgeon Expense	25% of Surgeon Benefit
Anesthesiologist	25% of Surgeon Benefit
Physiotherapy (Out-Patient)	$25 per visit, for up to 15 visits
X-rays, Imaging, MRI or Cat Scans (Out-Patient)	$150 maximum benefit
Laboratory Tests	$100 maximum benefit
Ambulance Services	$150 maximum benefit
Prescription Drug Benefit	$100 maximum benefit
Dental Benefit (sound, natural teeth only)	$1,000 maximum benefit
Medical Equipment Rental	$400 maximum
Accidental Death Benefit	$10,000 (including Death from Heart Failure)
Accidental Dismemberment Benefit	$10,000 maximum benefit
Accidental Paralysis Benefit	$10,000 maximum benefit
Aggregate Limit of Liability	$500,000 maximum benefit

Accident Medical Expense benefits are only payable in excess of any benefits provided by a Covered Person's primary health insurance.

USASA Contact Information
Nick Schmitt
nscmitt@usasa.com

Benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an illegal occupation;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
7. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental injury or accidental ingestion of contaminated food;
11. travel or activity outside the United States or Canada, unless approved by the Company;
12. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
13. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
14. injuries compensable under Workers' Compensation law or any similar law;

Benefits are not payable for:

15. services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Policyholder;
    b. living in the Covered Person's household;
    c. who is a parent, sibling, spouse or child of the Covered Person;
16. any Hospital Stay or days of a Hospital Stay that are not Appropriate Treatment for the condition and locality.
17. A Covered Person's Covered Loss if:
    a. he was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and
    b. he was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

None of the following will be considered Covered Expenses.

1. Blood, blood plasma or blood storage except expenses by a Hospital for processing or administration of blood.
2. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
    a cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
    b reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine treatment, surgery, health treatment or examinations.
4. Examination or prescriptions for, or purchase of, eyeglasses, contact lenses or hearing aids.
5. Treatment in any Veterans' Administration, Federal or state facility unless there is a legal obligation to pay.
6. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. Rest cures or custodial care.
8. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
9. Personal services such as television and telephone, or transportation.
10. Expenses payable by any automobile insurance policy without regard to fault.
11. Services or treatment provided by an infirmary operated by the Policyholder.
12. Treatment of injuries that result over a period of time, such as blisters, tennis elbow, et al, that are a normal, foreseeable result of participation in the Covered Activity.
13. Treatment or service provided by a private duty nurse.
14. Treatment of hernia of any kind.
15. Treatment of injury resulting from a condition that a Covered Person knew existed on the date of a Covered Accident, unless we have received a written medical release from his Physician.

Policy No UBH000002 is underwritten by QBE Insurance Corporation. This summary is not a contract. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations and exclusions are set forth in the Policy. To the extent there is any discrepancy between the descriptions in this brochure and the terms, conditions, limitations and exclusions of the Policy, the Policy shall prevail. Any policy QBE issues will be subject to the laws of the jurisdiction in which it is issued.

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.

AIG USI

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

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:

2a. Region:

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:_____ Title:_____

Signature of USASA Verification Officer:_____ Title:_____

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize A-G Administrators 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 A-G Administrators 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: _____ Date: _____

Signature of Coach, Manager or Referee: _____ Date: _____

AFTER you receive your acknowledgement letter, you may contact A-G Administrators at 800.634.8628 if you have any questions about your claim.

A-G Administrators, LLC: PO Box 979: Valley Forge, PA 19482
Email: Claims@agadm.com • Fax: 610.933.4122