COMPLETE AND RETURN THIS FORM TO:

P.O. Box 390 Short Hills, NJ 07078

ACCIDENT PROOF OF LOSS/CLAIM FORM

104 week benefit period

Section I: GENERAL INFORMATION

NAME OF CLAIMANT (First) (Last Name) (Middle Initial) | DATE OF BIRTH | ☐ Male ☐ Female

ADDRESS OF CLAIMANT (Street) (City) (State) (Zip code) | TELEPHONE NUMBER | OCCUPATION

NAME OF TEAM AND LEAGUE –OR- NAME OF CAMP/CLINIC/TOURNAMENT:

ARE YOU A MEMBER OF U.S. LACROSSE: ____ Yes _____ No
If Yes, provide US Lacrosse Member ID#: ______________________________
If no, you must be insured under the "Non-Member Insurance Program" to be eligible for coverage under this plan.

TYPE OF EVENT:
❑ PRACTICE ❑ CAMP/CLINIC ❑ TRAVEL
❑ GAME ❑ TOURNAMENT ❑ Other: ________________________

DESCRIBE PROTECTIVE EQUIPMENT WORN AT THE TIME OF INJURY:

THE CLAIMANT FOR WHOM THIS CLAIM FORM IS BEING FILED IS A:
❑ YOUTH PLAYER ❑ HIGH SCHOOL PLAYER ❑ BRIDGE MEMBER ❑ COLLEGIATE (MEN'S) ❑ COLLEGIATE (WOMEN'S) ❑ ADULT MALE
❑ ADULT FEMALE ❑ OFFICIAL/UMPIRE ❑ COACH ❑ MANAGER ❑ TRAINER ❑ OTHER: _____________

DATE & TIME OF ACCIDENT: | TYPE OF INJURY: | BODY PART INJURED:

FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE HOW ACCIDENT OCCURRED: ____
____
____

B. WHERE DID ACCIDENT OCCUR: ____
____
____

SECTION II TO BE COMPLETED BY AUTHORIZED OFFICIAL (required)

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICYHOLDER
January 1, 2008	**January 1, 2009**	**4102AH025220**	**U.S. Lacrosse, Inc.**

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	TELEPHONE NUMBER
113 West University Parkway	**Baltimore**	**MD 21210**	**410-235-6882**

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:**

SECTION III ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

SECTION IV STATEMENT OF OTHER INSURANCE (required)

Father/Claimant	**Mother/Claimant**
NAME:________________________	NAME:________________________
ADDRESS:________________________	ADDRESS:________________________
CITY:________________________	CITY:________________________
STATE: ____________ ZIP:__________	STATE: ____________ ZIP:__________
PHONE:________________________	PHONE:________________________
EMPLOYER:________________________	EMPLOYER:________________________
PHONE:________________________	PHONE:________________________
SELF EMPLOYED ☐ UNEMPLOYED ☐	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 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:**__________

SECTION VI: PLAYER ACTIVITY INFORMATION

PLEASE CHECK THE APPROPRIATE INFORMATION IN EACH OF THE FOLLOWING SECTIONS

1. LEVEL OF PLAY (check only one):
___ Youth/Recreation League
___ Middle School
___ BRIDGE Program
___ High School
___ College
___ Post-Collegiate Club
___ Adult Men's Team
___ Adult Women's Team

2. NATURE OF INJURY (check only one):
___ Sudden w/ Contact
___ Sudden w/o Contact
___ Gradual w/ Contact
___ Gradual w/o Contact

3. PRIMARY MECHANISM (check only one from A, B or C):

A. DIRECT IMPACT
___ Legal Object to Body
___ Illegal Object to Body
___ Legal Body to Body
___ Illegal Body to Body
___ Ball to Body
___ Fall to Ground Pushed by Body

B. INDIRECT IMPACT
___ Running Straight Ahead
___ Cutting/Dodging
___ Falling to Ground
___ Indirect w/ Torsion/Twisting Motion
___ Indirect w/ Stretching Motion
___ Indirect w/ Impingement
___ Indirect Overuse
___ Indirect Shearing
___ Indirect Other

C. COLLISION
___ Incidental Body Contact
___ Contact w/ Goal
___ Contact w/ Out-Of-Bounds Object

5. PLAYER ACTIVITY (check only one):

SHOT ON GOAL
___ Taking Shot
___ Field Player Defending Shot
___ Goalie Defending Shot

BALL POSSESION
___Offensive Player w/ Ball
___Defensive Player Marking Player w/ Ball

PASSING
___ Delivering A Pass
___ Catching A Pass

OFF BALL
___ Off Ball, Offensive Player
___ Off Ball, Defensive Player

OTHER, NON-CONTACT
___ Agility Drill
___ Skill Drills
___ Sprinting
___ Endurance Training
___ Strength Training

6. PLAYER POSITION (check only one):
___Attack
___ Midfield
___ Defense
___ Goalie
___ Official/Referee
___ Coach
___Other Non-Participant

7. LOCATION (check only one):
___ Playing Offense at Offensive End of the Field
___ Playing Defense at Offensive End of the Field
___ Playing Offense at Defensive End of the Field
___ Playing Defense at Defensive End of the Field
___ Playing Offense in Midfield
___ Playing Defense in Midfield
___ Playing Offense Near the Crease
___ Playing Defense Near the Crease

8. TEAM SESSION:
____Practice
___ Game
___ Penalty at Time of Injury
___ Injury Caused by Penalty

4. TEAM ACTIVITY (check only one in settled or unsettled):

SETTLED:
___ Half Field Offense
___ Half Field Offense- Shot
___ Half Field Defense
___ Half Field Defense Shot
___ Clearing-Offense
___ Riding-Defense

UNSETTLED:
___ Ground Ball/Loose Ball
___ Fast Break Offense
___ Fast Break Offense Shot
___ Fast Break Defense
___ Fast Break Defense Shot
___Transition Offense
___ Transition Defense
___ Face-Off/ Draw

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 **104 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 104 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **104 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. Please be aware of the deductible that will be applied to your claim:
   a. Adult Male Players: **$2,500.00**
   b. All Other Players, Coaches and Officials: **$500.00**

5. Make sure that an authorized official of your local Lacrosse team or league has signed the Claim Form under the "Verification of Covered Activity" (signature #1). The coach, manager or referee who can verify that the injury took place during a sponsored amateur lacrosse activity may sign the form. If this accident occurred during a camp, clinic or tournament, the director or coach or referee who can verify that the claim took place during a sponsored activity must sign the Claim Form. **Do not send the claim to the U.S. Lacrosse National office for verification.**

6. Player Activity Information (Section VI): For the purpose of an injury study being conducted by the Sports Science and Safety Committee, please complete this section to further describe how the injury occurred.

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

8. **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 Insurance, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-2876
www.BollingerLAX.com

For further information contact:
US Lacrosse
113 W. University Parkway
Baltimore, MD 21210
Phone: 410-235-6882
Fax: 410-366-6735
info@uslacrosse.org

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