USGAA 2018 Claims Guide

By Connor, Alexander and Sullivan Insurance Services

COMPLETE AND RETURN THIS FORM TO:

P.O. Box 390 Short Hills, NJ 07078

Medical/Dental Accident
CLAIM FORM

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☐ SS#:__________
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 OCCURED:__________

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	Policy Expiration Date	Policy #	Name of Policyholder
04-15-2017	04-15-2018	4102AH008885 - 3	North American Board - Gaelic Athletic
ADDRESS OF POLICYHOLDER (Street) (City) (State) MPS 14300 S. Ravinia Ave., #201 Orland Park, IL 60462			TELEPHONE NUMBER

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

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

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. AUTHORIZED SIGNATURE:	TITLE:	DATE:

RPS Bollinger Claim Form: Page 1 Important Points

- Q7: LEFT or RIGHT body part needs to be stated, eg *left ankle*
- Section III: Tick box ‘Yes- Claimant was an active member…’
- Section III: Cannot be left blank. Needs to be signed by authorized official, eg club manager, board member, referee.

RPS Bollinger Claim Form: Page 2 Important Points

SECTION IV	STATEMENT OF OTHER INSURANCE	(required)

Claimant/Father
Name:
Address:
City:
State: Zip Code:
Phone:
Employer:
Phone:
Self Employed ☐ Unemployed ☐
Email:

Claimant/Mother
Name:
Address:
City:
State: Zip Code:
Phone:
Employer:
Phone:
Self Employed ☐ Unemployed ☐
Email:

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

POLICYHOLDER NAME: ______ **ID#:** ______
INSURED GRP#/NAME:
INSURANCE 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	(required)

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING PROVIDED INDICATES PAYMENT MADE BY YOU.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION	(required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (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 RPS Bollinger or Markel Insurance Company or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required): ______ **DATE:** ______

- Section IV: Only provide your parents information if you are under 18. If over age 18 it's your own information needed.
- If you have health insurance, check Yes and provide information PLUS a scanned copy of your medical card.
- If you don't have health insurance, check No and provide a letter from your employer stating you don't have health insurance
- If the injured player is married then he/she needs to complete the Mother/Father section except with SPOUSE
- Your signature is needed (twice) at the end of the page

Medicare Form: Page 1 Important Points

- Section I: If you have medicare, please complete this section

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?				☐Yes	☐No
If yes, please complete the following. If no, proceed to Section II.					
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*					
Medicare Claim Number:		**Date of Birth (Mo/Day/Year)**	- -		
Social Security Number: *(If Medicare Claim Number is Unavailable)*	- -	**Sex**	☐Female	☐Male	

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

______________________________ ______________________________

Claimant Name (Please Print) **Claim Number**

____

Name of Person Completing This Form If Claimant is Unable (Please Print)

______________________________ ______________________________

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Medicare Form: Page 2 Important Points

- Section 2: If you don’t have medicare, please complete this section

Section III

____________________________ ____________________________

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

____

____

____

____

____________________________ ____________________________

Signature of Person Completing This Form **Date**

USGAA Incident Report: Page 1 Important Points

- LEFT or RIGHT body part needs to be stated, eg *left ankle*
- Witness's section needs to be filled out by coach, team-mate, physio, etc

USGAA Incident Report Form

(PLEASE PRINT)

INJURED PERSON INFORMATION:

Last Name ______ First Name ______ MI ____
Employer ______ Spouse's Name ______
(If Minor) Father's Name: ______ Mother's Name ______
Address ______ Email ______
City ______ State ______ Zip ______ Phone (____) ______
Social Security Number ______ Date of Birth ______ Current Age ______ Male Female
Are you a (choose one): ATHLETE COACH OFFICIAL OTHER ______

TIME, PLACE AND DETAILS OF INCIDENT:

Date of Incident ______ Time of Incident ______ AM PM
Body Part Injured: ______
Type of injury (choose one): Laceration Sprain/Strain Fracture Contusion Concussion Other: ______
Severity (choose one): Report only Minor Serious Critical Fatality
Did you receive onsite care? Y N Were you taken by ambulance to a hospital? Y N
What event were you participating in at the time of the incident? ______
Was there a certified Coach at this event? Y N If so include name ______
What was the location of the event? ______
Describe what happened: ______

Was there a witness to the incident? Y N

WITNESSES:

(If there was a witness please complete this section)
Witness name: ______ Address: ______
______ Phone: ______
Witness name: ______ Address: ______
______ Phone: ______

FAMILY HEALTH INSURANCE:

(Health Insurance MUST be filed prior to this policy)
Insurance Company: ______
Policy holder's name: ______
Policy Number: ______

USGAA Incident Report: Page 1 Important Points

Group Number: ____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE AIG, GLOBAL SPORTS SERVICES, OR THEIR 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 AIG, GLOBAL SPORTS SERVICES, OR THEIR REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, 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.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM. BY MY SIGNATURE BELOW I CERTIFY THAT I HAVE LISTED ANY EXISTING HEALTH INSURANCE COVERAGE ABOVE AND UNDERSTAND THAT OMISSION OF REQUESTED INFORMATION OR FRAUDULENT STATEMENTS CAN BE A CRIME.

Claimant Signature______________________________ Date ________________

This section to be completed and signed by NAB GAA Certified Coach or Official:

Club Name of injured: ______________________________

County where incident occurred: ______________________________

I ASSERT THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INCIDENT OCCURRED ON THIS DATE ________

WHILE (athlete, coach or Official name) ____________________ WAS PARTICIPATING IN A SANCTIONED NAB GAA EVENT.

COACH or OFFICIAL NAME (print) ____________________ Title ________

COACH or OFFICIAL SIGNATURE ____________________ Date ________

- Claimant signature required
- Signature required by coach/manager

Receipts...receipts...receipts

- Keep ALL receipts. The more paperwork a claimant has to support his/her claim the better.
- RPS Bollinger will correspond with you for proof of payment.

Deductible

There is a **$500** deductible that the player will have to pay out of their own pocket towards a claim.

What's a deductible?

A deductible is the amount of money that the insured must pay before an insurance company will pay a claim

Accident Coverage:

Accidental Medical & Dental Expense Limit: $ 50,000. Maximum

Accidental Death & Dismemberment Limit: $ 5,000. Principal Sum

Aggregate Limit per Accident: $1,000,000.

Deductible per Youth Participant: $ 500. Per Injury

Deductible per Adult Participant: $ 500.

Per Injury Benefit Period: 52 Weeks from date of Injury

Claims Basis: Full Excess

Coinsurance clause: 80%

Cat Cash Benefit for Catastrophic Injuries: $10,000

The Aggregate Maximum is the most we will pay, regardless of number of insureds, for any one accident.

Deductible is flat deductible (corridor), regardless of any other insurance.

The accident policy contains the following sub-limits:

- $2,000 Benefit for Chiropractic/Physical Therapy subject to a $50 per visit limit
- $1,000 Benefit for Durable Medical Equipment
- $1,000 Benefit for Prescription Drugs

Accident Coverage Ctd:

The Aggregate Maximum is the most we will pay, regardless of number of insureds, for any one accident. Deductible is flat deductible (corridor), regardless of any other insurance. The accident policy contains the following sub-limits: • $2,000 Benefit for Chiropractic/Physical Therapy subject to a $50 per visit limit • $1,000 Benefit for Durable Medical Equipment • $1,000 Benefit for Prescription Drugs

Questions?

For questions regarding claims, forms, etc, feel free to reach out to:

Kevin Sullivan- CEO Founder, *Connor, Alexander and Sullivan Insurance Services*

Email: kevin@consulinsurance.com

Phone: 415-841-3038

And/or to:

Danielle Downey- Office Ninja, *Connor Alexander and Sullivan Insurance Services*

Email: danielle@consulinsurance.com