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Insurance and Risk Management Services Sponsored By Bollinger.

Missouri Youth Soccer Association

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TO BE COMPLETED BY CLAIMANT			
NAME OF CLAIMANT (Last Name)		(First Name)	(Middle Name)
ADDRESS OF CLAIMANT (Street)		(City)	(State) (Zip code)
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
TELEPHONE NUMBER ()		OCCUPATION	
DATE & TIME OF ACCIDENT		ACCIDENT DUE TO EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NATURE OF INJURY			
FOR ACCIDENTAL INJURIES PLEASE COMPLETE THE FOLLOWING:			
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT			

B. PLACE OF ACCIDENT (BE SPECIFIC)			

C. DESCRIBE HOW ACCIDENT HAPPENED			

MEDICAL AUTHORIZATION

I hereby authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disability.	Please sign here: _____	
	Claimant (if adult) or Parent/ Guardian	Date

PAYMENT AUTHORIZATION

I hereby authorize payments of benefits directly to the providers rendering services.	Please sign here: _____	
	Claimant (if adult) or Parent/ Guardian	Date

STATEMENT OF OTHER INSURANCE

1. Name and Address of Claimants Employer: (If a minor, complete # 2 & 3)			
2. Father's Name or Guardian:	Occupation:	Name and Address of His Employer:	Phone #:
3. Mother's Name or Guardian:	Occupation:	Name and Address of Her Employer:	Phone #:
4. Do you have a Group, Personal Healthcare or Medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of your Health Care Provider		Address	

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature _____ **Date** _____
 Claimant (if Adult) or Parent/Guardian

TO BE COMPLETED BY POLICYHOLDER / ADMINISTRATOR				
POLICY NUMBER PST2255V	CLAIM OF GROUP POLICYHOLDER Missouri Youth Soccer Association			
ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	(Zip Code)	
5650 Mexico Rd. Suite 22	St. Peters	Mo.	63376	
TELEPHONE NUMBER (636) 947-8442				
IF ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SUPERVISED BY YOUR ORGANIZATION, DESCRIBE ACTIVITY, HOW ACCIDENT OCCURRED, AND SPECIFY DATE OF OCCURRENCE.				
REMARKS:				

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. AUTHORIZED SIGNATURE: _____	TITLE _____	DATE _____
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INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM:

1. **IMMEDIATELY** submit a claim for all medical expenses to the Company that administers your own personal or group insurance or healthcare plan (including Major Medical coverage). If you have coverage through an HMO or similar facility, you must use that facility first or the claim will not be covered under this policy.
2. After your other insurance or healthcare plan has paid the medical expenses up to the policy limits, attach any unpaid bills and copies of payments made by your insurance company (Explanation of Benefits) to this claim form and mail to the address shown below.
3. Please check and make sure that:
 - a. An Official or Administrator of the Policyholder has completed his/her section of the claim form.
 - b. You have completed and signed the Parent/Guardian or Insured's Statement of other Insurance.
 - c. The Medical Records Authorization **MUST** be signed and dated. If you want payments to be sent directly to your doctor or healthcare provider, sign the Payment Authorization Section.
 - d. You have attached all unpaid bills to this form.
 - e. You have attached any Explanation of Benefits forms that you have received from your Primary insurance carrier or other healthcare plan.
 - f. You have completed the front of this form.
4. Subsequent bills should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new claim form is not necessary.**

If you need further information, call Bollinger at 800-526-1379. Our Accident Claims fax number is 973-467-0759.

MAIL THIS FORM AND ALL ITEMIZED BILLS TO:
Missouri Youth Soccer Assoc.
Beverly Spearman
5650 Mexico Rd. Suite 22
St. Peters, Mo. 63376

PLAN ADMINISTRATOR:
BOLLINGER, INC.
P.O. BOX 390, SHORT HILLS, NJ 07078-0390
TELEPHONE 1-800-526-1379