

**Amateur Softball Association
Individual Registration Accident Claim Form**

COMPLETE AND RETURN THIS FORM TO:



P.O. BOX 390, Short Hills, NJ 07078-0390

SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE SUBMIT COPY OF ID CARD

TO BE COMPLETED BY CLAIMANT					
NAME OF CLAIMANT (Last Name)	(First Name)	(Middle Initial)	TELEPHONE NUMBER	DATE OF BIRTH	<input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS OF CLAIMANT (Street) (City) (State) (Zip code)			NAME OF YOUR LEAGUE	NAME OF YOUR TEAM	
DATE & TIME OF ACCIDENT		TYPE OF INJURY		<input type="checkbox"/> FASTPITCH <input type="checkbox"/> SLOWPITCH	

FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. PART OF BODY INJURED:

B. PLACE OF ACCIDENT (BE SPECIFIC)

C. DESCRIBE HOW ACCIDENT HAPPENED

MEDICAL AUTHORIZATION (Required)	PAYMENT AUTHORIZATION (Optional)
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 please sign above Date _____	I hereby authorize payment of benefits directly to the providers rendering services. Please sign here _____ Claimant (if Adult) or Parent/Guardian please sign above Date _____

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED			
1. Name and Address of Claimant's 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 <input type="checkbox"/> Self employed <input type="checkbox"/> Unemployed			
Name of your INSURANCE CARRIER (medical and/or dental)		Address/Phone number	

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

VERIFICATION: (Must be signed by Team/League Official)
I certify that the above name claimant is an insured member of the team named above and that the injury occurred during official team activities as stated.
Name of Team/League Official: _____ Title: _____
Signature of Team/League Official: _____ Date: _____ Phone #: _____

VERIFICATION: (Must be signed by ASA State or Metro Commissioner or an ASA Official Designated by State or Metro Commissioner)
To the best of my knowledge, the facts outlined above are true and complete. I hereby verify that the claimant is a registered member of the Amateur Softball Association of America for the current season.
Name: _____ Signature: _____
Title: _____ Date: _____ Phone#: _____
Indicate deductible option selected for player/claimant at the time of registration: _____\$0 _____\$100 _____\$250

IMPORTANT: Claims CANNOT Be Processed Unless All Information is Provided.

1. Accident medical expense coverage 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 in order for this policy to consider your expenses for payment. You must send copies of any and all payments (or denials) made by your insurance plan with the claim form. Also include any Explanation of Benefits (EOB) statements.
2. **The Statement of Other Insurance section must be fully completed. If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.**
3. This accident insurance provides benefits on a limited basis. Treatment for a covered injury under this policy must begin within **60 days** of the date of injury. This policy is subject to a **52-week benefit period**. This means only those medical or dental expenses that are incurred **within 52 weeks** (1 year) of the date of injury are eligible for coverage under this policy. Any expenses or treatments that take place after the **52-week** benefit period cannot be covered by this policy.
4. You must attach itemized bills from your doctor, dentist or hospital. If information on bills is incomplete, we will request additional information, which will delay payment. In the event of hospitalization, we may need to request medical records from the hospital before processing the claim for payment.
5. Please make sure that you have signed the Claim Form and the Medical Authorization section on the Claim Form. If you want us to pay the providers directly, you must sign the authorization to make payment to the provider of services.
6. Make sure that an authorized official of your team or league has signed the Claim Form and that the claim has also been signed by your ASA State or Metro Commissioner.
7. Only one Claim Form is necessary for each accident. Subsequent bills can be submitted as you receive them. Please indicate Claimant's name and Date of accident on all subsequent bills.
8. **Flexible Spending Account:** You must submit your bills through your primary insurance carrier and Bollinger Insurance first before accessing your Flexible Spending Account within your company.
9. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before submitting the bills to Bollinger Insurance.
10. **Important Note:** Due to HIPAA Regulations, Bollinger Sports Claims is no longer accepting information via fax.

For further information contact:

Bollinger Insurance, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
www.BollingerASA.com
www.BollingerInsurance.com

Bollinger
Insurance Since 1876