



## CLAIM INSTRUCTIONS – Cal South Youth Soccer Accident Insurance (SAI)

These Instructions are to be used for completing the SAI CLAIM FORM for injuries occurring at Cal South sanctioned events STARTING July 1, 2020 - June 30, 2021.

**\*\* NOTE: The claim form AS FOLLOWS should be submitted to AIG Accident & Health Claims Dept. (US) –** addressed below—as soon as possible after medical treatment has been administered for an injury occurs and not later than 30 days after first incurred treatment. Once any other primary carrier has paid, send a copy of the itemized bill and primary carrier Explanation of Benefits “EOB” to AIG for additional benefit consideration. It is suggested to keep copies of everything sent to AIG.

**GENERAL INFORMATION** - There is a 52 Week Benefit Period starting July 1, 2020 - June 30, 2021. Injuries must be sustained during that time period. **First incurred treatment for injuries must be incurred within 90 days of the injury. The claim form must be received by AIG within 30 days of the first incurred treatment expense.**

**POLICIES WITH EXCESS COVERAGE** - Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB’s (explanation of benefits) from the primary insurance. If no primary coverage exists, the SAI coverage will act as a primary insurance subject to all policy terms and conditions.

**CLAIM FORM** - The claim form must be submitted for each individual claim. Section A must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. Section B must be completed in full and signed by all parties shown. Section C must be completed in full and signed by all parties shown. **A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.**

**DEDUCTIBLE (\$1,000 AND 20% MEMBER COINSURANCE)** - Each claim is subject to the \$1,000 deductible and 20% Coinsurance. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

**MEDICAL BILLS** - Notify all medical providers – hospitals and doctors – if you will be using this insurance alone or along with your primary insurance. **Provide them with the name and mailing address to AIG (provided below) and request that they submit the required insurance billing forms there.** A physician’s office should submit a CMS 1500. A hospital and/or emergency room should submit a UB04. **A balance due statement is not acceptable and will only delay processing.**

**INFORMATION REQUESTS** - In the event that a claim is not submitted in full or if additional information is needed, the claim will be suspended, and the additional information will be requested via US Mail. Please forward the requested information immediately to AIG Accident & Health Claims Dept. to prevent delay in the adjudication of your claim

**CLAIM SUBMISSION CHECKLIST – Use the below checklist to assure a properly submitted medical claim is to be sent.**

	YES	NO
If the injured person has primary health insurance has the claim been submitted first to the primary insurance <i>if available</i> .		
If claim was first submitted to the primary, are copies of the EOB’s (explanation of benefits) <i>if available</i> , attached.		
Have you requested itemized medical bills - CMS1500 or UB04 - to be sent directly to AIG Accident & Health Claims Dept.? <ul style="list-style-type: none"> <li>■ Address: AIG Accident &amp; Health Claims, Po Box 25987, Shawnee Mission, KS 66225-5987</li> </ul>		
Have Parts A & Parts B of the Claim Form been completed in its entirety?		
Has Part C of the Claim Form been completed and signed by all the appropriate Officials?		

### MAILING THE CLAIM FORMS & DOCUMENTS

When completed, claimant should mail the claim form including itemized medical bills (if not mailed directly to AIG by the medical providers) and copies of EOB’s (explanation of benefits from primary insurance) to:

**AIG Accident & Health Claims, P.O. Box 25987, Shawnee Mission, KS 66225-5987,**  
Phone: 800-551-0824, Fax: 866-893-8574, Email: A&Hclaimssubmissions@aig.com  
(Tip: We recommend mailing everything Certified/Return Receipt and to keep copies of all documents)

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the AIG claims office at **800-551-0824**.



**CAL SOUTH ACCIDENT CLAIM FORM – REGISTERED YOUTH PROGRAM**

**AIG Accident & Health Claims**

P.O. Box 25987, Shawnee Mission, KS 66225

Phone: 800-551-0824, Fax: 866-893-8574, [www.aig.com](http://www.aig.com)



**Part A – This Part MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under the age of 18 or otherwise dependent, by his / her Parent or Guardian.**

Organization's Name: California State Soccer Association – South

Policy# : SRG 0009137627-B (Registered Youth Program)

Organization's address: 1029 S. Placentia Ave. Fullerton, CA 92831

Name of Injured Person: \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Check one:  Injured Person  Parent  Guardian

Give the following information about the Injured Person:

Date of birth: \_\_\_\_\_ SSN/Visa/Green Card: \_\_\_\_\_

Gender of Injured Person: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ Email address: \_\_\_\_\_

Explain HOW the injury occurred and describe the nature of the injury: \_\_\_\_\_

Body part injured: \_\_\_\_\_ Date of injury: \_\_\_\_\_

Describe WHERE the accident: \_\_\_\_\_

Field Name/Loc: \_\_\_\_\_ Tournament Name/Loc: \_\_\_\_\_

At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes  or No

Name of Supervisor of Activity: \_\_\_\_\_ Was he/she a witness to the accident? Yes  or No

**Part B – Primary Insurance (must be completed in full and signed by all parties )**

Is Injured Person covered under any other health and / or accident insurance plans? Yes  or No

If answer is yes, indicate name of other insurance company: \_\_\_\_\_

Company's address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Policy number(s): \_\_\_\_\_ Name of Policyholder(s): \_\_\_\_\_

Employer name: \_\_\_\_\_ Employer phone number: \_\_\_\_\_

Employer address: \_\_\_\_\_

If the Injured Person is under 18 or otherwise independent, give the following information:

Name of Father or Male Guardian: \_\_\_\_\_ SSN/Visa/Green Card: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Area Code/Employer Phone No. \_\_\_\_\_

Name of Mother or Female Guardian: \_\_\_\_\_ SSN/Visa/Green Card: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Area Code/Employer Phone No. \_\_\_\_\_

**Part C – Affiliate Member Verification (to be completed by cal south club/league coach & president)**

Affiliate Member ID (3 digits) #: \_\_\_\_\_ Player ID#: \_\_\_\_\_

Affiliate Club/League Name: \_\_\_\_\_ Play Type:  Competitive  Camp/Clinic  Recreational/Signature

We do hereby authorize that the claimant is a properly registered player with Cal South and that the injury was sustained during a Cal South sanctioned event.

Signature of Cal South Coach of Injured Claimant : \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Cal South Affiliate Member President : \_\_\_\_\_ Date: \_\_\_\_\_

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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.

**AUTHORIZATION and ASSIGNMENT OF BENEFITS**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. Yes  or No

Claimant's or Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Authorized Representative, Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

## State Fraud Notices

FOR USE ON ALL APPLICATIONS AND CLAIM FORMS

**GENERAL** – ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OR CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT.

**ALASKA:** A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW.

**ARIZONA:** FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**ARKANSAS, LOUISIANA, RHODE ISLAND, AND WEST VIRGINIA:** 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.

**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.

**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 OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**CONNECTICUT:** THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. INTENTIONALLY MISREPRESENTS OR INTENTIONALLY FAILS TO DISCLOSE ANY MATERIAL FACT RELATED TO A CLAIMED INJURY MAY BE GUILTY OF A FELONY.

**DELAWARE, IDAHO, INDIANA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**DISTRICT OF COLUMBIA:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**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.

**HAWAII:** FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

**KANSAS:** ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

**KENTUCKY:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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.

**MAINE:** 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 OR A DENIAL OF INSURANCE BENEFITS.

**MICHIGAN, NORTH DAKOTA, SOUTH DAKOTA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES A 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 SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

**MINNESOTA:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NEVADA:** ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER STATE OR FEDERAL LAW, OR BOTH, AND MAY BE SUBJECT TO CIVIL PENALTIES.

**NEW HAMPSHIRE:** ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN RSA 638.20.

**NEW JERSEY:** ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**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.

**OHIO:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**OKLAHOMA:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**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 THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**TEXAS:** ANY PERSON WHO KNOWINGLY PRESENTS A 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.

Insurance is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. and The Insurance Company of the State of Pennsylvania. AIG Claims, Inc. is an authorized claims administrator for National Union Fire Insurance Company of Pittsburgh, Pa. and The Insurance Company of the State of Pennsylvania.



View the U.S. Privacy policy at [www.aig.com/privacy-policy](http://www.aig.com/privacy-policy).

SM-11874-19 (NR) R07/19