Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000 Email: aciclaims@acitpa.com
Phone: 888-293-9229 Fax: 610-293-9299

AYSO ACCIDENT CLAIM FORM

Part A MUST be completed, dated and signed by Injured Person or by parent / legal guardian if Injured Person is under 18 years old.

American Youth Soccer Association
Organization Name
19700 S. Vermont Ave., Suite 103, Torrance, CA 90502
Organization Address, City, State, Zip

AHP1200090-251
Policy #

Name of Injured Person (First Name/Last Name)

Parent / Legal Guardian Name (if injured person under 18 years old)

Person Completing Form:

☐ Injured Person
☐ Parent
☐ Legal Guardian

Complete the following information about Injured Person:

Date of Birth (mm/dd/yy) | Social Security Number | Gender: ☐ Male ☐ Female

Address | City, State, Zip

Phone Number | E-Mail Address

Employer | Employer Phone Number

Employer Address | City, State, Zip

Is Injured Person covered under other health and/or accident insurance plans? ☐ Yes ☐ No If yes, provide insurance company information.

Insurance Company Name | Address | Phone Number

Name of Policyholder(s) | Policy Number(s)

Employer Address | City, State, Zip

If Injured Person is under 18 years old, provide the following information:

Father / Legal Guardian Name

Employer Name | Employer Phone Number

Mother / Legal Guardian Name

Employer Name | Employer Phone Number

Explain HOW the accident / injury occurred and describe the nature of the injury.

Body Part injured

AHP1200090-251

Part B Must be completed by an AYSO Official.

Name of Injured Person (First Name/Last Name)

Date of Accident / Injury (mm/dd/yy)

Regional Commissioner or Safety Director Signature

Date

Location of Injury: ☐ Practice ☐ Travel ☐ Game ☐ Other: _____

AYSO Region Number

AYSO Player / Volunteer ID Number

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

Name of Supervisor of Activity

Was the Supervisor a witness to the accident? ☐ Yes ☐ No

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

PERSONAL INFORMATION NOTICE AND CONSENT: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by the Insurance Company named above or its representatives (the "Insurer") to assess my entitlement to benefits, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside the United States for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.

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 or reinsurance company, workers compensation board or similar plan or organization, association or institution, 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 a period of two (2) years from the date hereof, 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.

REMITTING THE CLAIM FORM: When completed, claimant (or parent/guardian) should make copies of all documents and mail, fax, or email the claim form including itemized medical bills (if not mailed directly to Administrative Concepts, Inc. by the medical providers) and copies of EOB's (explanation of benefits from primary insurance) to:

Administrative Concepts Inc
aciclaims@acitpa.com
PO Box 4000, Collegeville, PA 19426 ; Fax: 610-293-9299

If you should have any questions or if a physician's office or hospital needs to confirm benefits before a medical procedure, contact ACI at 610-293-9229.

FRAUD NOTICE:

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.

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.

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.

Signature of Injured Person or Authorized Representative

Date

If Authorized Representative, relationship to Injured Person

Date