NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for accident medical claims.

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 insurance or medical payment plan they must first submit claim to the primary insurance first. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Deductible ($200.00)

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. 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.

Claim Form

This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) 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. A fully completed claim form is not necessary when submitting additional medical bills, only one claim form is needed per accident/injury.

Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per HCFA 1500. A hospital and/or emergency room should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary? _____

If claim has first been submitted to the primary, are copies of EOB's (explanation of benefits) attached? _____

Is part (A) of the claim form completed by the Policyholder official or staff member and signed? _____

Is part (B) of the claim form completed by the injured person and signed? _____

Are the attached medical bills itemized in either a HCFA 1500 or UB92 form? _____

Is part (B), item number 3 (social security number) completed? _____

Mailing The Claim
When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

Dianna Taormina
American National Life Insurance Company of Texas
AYSO Accident Claims
The Loomis Company
P.O. Box 13906
Reading, PA 19612

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 claims office at (888) 585-7065 or (800) 782-0392.

Documents may also be faxed to the claims office at (630) 665-7294. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanations of benefits are available for reimbursement.

ACCIDENT DEDUCTIBLE CREDIT SHEET

INJURED'S NAME _____

POLICYHOLDER'S NAME _____

DATE OF INURY _____

NAME & ADDRESS CHECK SHOULD BE SENT TO:

_____

_____

_____

PROVIDER	DATE OF SERVICE	$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. 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.

AMERICAN NATIONAL

NOTICE

WARNING: 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 may be guilty of a crime and may be subject to civil fines and criminal penalties. California Residents: 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."

PART A — This PART **MUST** be **completed, dated** and **signed** by an official or the Organization.

1. Name of Organization (Policyholder)
American Youth Soccer Organization

2. Policy No.
FLD03-56378-BC

3. AYSO Region No.

4. Name of Organization or Team (if different from Policyholder)

5. Address of Organization (Street) (City) (State) (Zip)

6. Name of Injured Person (Insured) (First) (Middle) (Last)

7. AYSO ID

8. Date of Accident/Injury	9. Injury Occurred:	10. Type of Sport or Activity:
Mo. Day Year / /	Practice ❑ Travel ❑ Game ❑ Other_____	

11. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.

12. Describe the nature of injury.

13. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ❑ No ❑	14. Name of Supervisor of Activity	15. Was he/she a witness to Yes ❑ No ❑

16. AYSO Regional Commissioner Signature	17. Date Signed	18. AYSO Safety Director Signature	19. Date Signed
X_____		X_____	

PART B — This PART **MUST** be **completed, dated** and **signed** by the Injured Person — or if the Injured Person is under age 18 or otherwise dependent — by his/her Parent or Guardian.

PRINT HERE — NAME OF PERSON COMPLETING FORM

Check one: Injured Person ❑ Parent ❑ Guardian ❑

Give the following information about the Injured Person:

1. Date of Birth Mo. Day Year / /	2. Male ❑ Female ❑	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ( )

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ❑ No ❑
If YES, give the following information:

Name of Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

Name of Mother or Female Guardian — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

9. If the Injured Person is married, give the following information:

Name of Spouse — Social Security No. / /

Place of Employment

Address of Employer — Area Code/Employer Phone No. ( )

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to American National Life Insurance Company of Texas or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. i understand that i or my authorized representative will receive a copy of this authorization upon request.

X_____ _____ Check one: ❑ Injured Person ❑ Parent ❑ Guardian Date:_____

Signature (in writing) of Responsible Party — Print Name