COMPLETE AND RETURN THIS FORM TO:

Bollinger Insurance Solutions

P.O. Box 390
Short Hills, NJ 07078

Medical/Dental Accident CLAIM FORM

USLacrosse

104 week benefit period

SECTION I GENERAL INFORMATION

1. NAME: (first) _____ (last) _____
2. ADDRESS: _____
   CITY: _____ STATE: _____ ZIP: _____
3. PHONE: _____
4. BIRTHDATE: _____ GENDER: ☐ Male ☐ Female
5. NAME OF TEAM AND LEAGUE - OR - NAME OF CAMP/CLINIC/TOURNAMENT:

_____

6. ACCIDENT OCCURRED DURING: ☐ GAME ☐ PRACTICE ☐ TOURNAMENT ☐ CAMP/CLINIC ☐ TRAVEL ☐ OTHER
7. CLAIMANT IS A: ☐ YOUTH PLAYER ☐ HIGH SCHOOL PLAYER ☐ BRIDGE MEMBER ☐ COLLEGE PLAYER (MEN'S) ☐ COLLEGE PLAYER (WOMEN'S) ☐ ADULT MALE ☐ ADULT FEMALE ☐ OFFICIAL/UMPIRE ☐ COACH ☐ MANAGER ☐ TRAINER ☐ OTHER
8. ARE YOU A MEMBER OF U.S. LACROSSE: ☐ Yes ☐ No

IF YES, PROVIDE US LACROSSE MEMBER ID#: _____

If No, you must be insured under the "Non-Member Insurance Program" to be eligible for coverage under this plan.

9. ACCIDENT DATE: 1/1/2010 ACCIDENT TIME: _____
10. BODY PART INJURED: _____
11. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:

_____

_____

_____

12. DESCRIBE PROTECTIVE EQUIPMENT WORN AT TIME OF INJURY:

_____

_____

_____

13. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:

_____

SECTION II TO BE COMPLETED BY AUTHORIZED OFFICIAL (REQUIRED)

THIS SECTION MUST BE FILLED OUT AND SIGNED BY THE DIRECTOR OR AUTHORIZED PERSON IN YOUR SPORTS ORGANIZATION IN ORDER FOR THIS CLAIM TO BE PROCESSED.

POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	POLICY #	NAME OF POLICY HOLDER
January 1, 2010	January 1, 2011	4102AH025220	U.S. Lacrosse, Inc

ADDRESS OF POLICY HOLDER (STREET)	(CITY)	(STATE)	(ZIP)	PHONE NUMBER
113 West University Parkway	Baltimore	MD	21210	410-235-6882

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT.

☐ YES-SPONSORED/SANCTIONED ACTIVITY

☐ YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

AUTHORIZED SIGNATURE: _____ **TITLE:** _____ **DATE:** _____

SECTION III STATEMENT OF OTHER INSURANCE (REQUIRED)

RELATIONSHIP TO CLAIMANT: (CIRCLE ONE)
SELF FATHER MOTHER GUARDIAN SPOUSE

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ **ZIP:** _____
PHONE: _____
EMPLOYER: _____
EMPLOYER PHONE: _____

☐ **EMPLOYED** ☐ **SELF-EMPLOYED** ☐ **UNEMPLOYED**

RELATIONSHIP TO CLAIMANT: (CIRCLE ONE)
SELF FATHER MOTHER GUARDIAN SPOUSE

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ **ZIP:** _____
PHONE: _____
EMPLOYER: _____
EMPLOYER PHONE: _____

☐ **EMPLOYED** ☐ **SELF-EMPLOYED** ☐ **UNEMPLOYED**

(If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.)

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? ☐ **YES** ☐ **NO**

IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? ☐ **YES** ☐ **NO**

INSURED NAME: _____
ID#: _____
INSURED GROUP#/NAME: _____
COMPANY NAME: _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____
PHONE: _____

NOTE: IF THE INJURED HAS MEDICAL COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS, AND PHONE NUMBER OF THE RESPONSIBLE PARTY.

_____
_____
_____

SECTION IV ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

SECTION V STATEMENT OF CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION (REQUIRED)

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantial civil penalty to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/CLAIMANT (REQUIRED): _____ **DATE:** _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT/CLAIMANT (REQUIRED): _____ **DATE:** _____

SECTION VI PLAYER ACTIVITY INFORMATION

1. LEVEL OF PLAY (Check only one):

- ☐ Youth/Recreation League
- ☐ Middle School
- ☐ BRIDGE Program
- ☐ High School
- ☐ College
- ☐ Post-Collegiate Club
- ☐ Adult Men's Team
- ☐ Adult Women's Team

2. NATURE OF INJURY (Check only one):

- ☐ Sudden w/ Contact
- ☐ Sudden w/o Contact
- ☐ Gradual w/ Contact
- ☐ Gradual w/o Contact

3. PRIMARY MECHANISM (Check only one from A, B or C):

A. Direct Impact

- ☐ Legal Object to Body
- ☐ Illegal Object to Body
- ☐ Legal Body to Body
- ☐ Illegal Body to Body
- ☐ Ball to Body
- ☐ Fall to Ground Pushed by Body

B. Indirect Impact

- ☐ Running Straight Ahead
- ☐ Cutting/Dodging
- ☐ Indirect w/ Torsion/Twisting Motion
- ☐ Indirect w/ Stretching Motion
- ☐ Indirect w/ Impingement
- ☐ Indirect Overuse
- ☐ Indirect Shearing
- ☐ Indirect Other

C. Collision

- ☐ Incidental Body Contact
- ☐ Contact w/ Goal
- ☐ Contact w/ Out-Of-Bounds Object

4. TEAM ACTITIVY (Check only one in settled or unsettled):

Settled:

- ☐ Half Field Offense
- ☐ Half Field Offense-Shot
- ☐ Half Field Defense
- ☐ Half Field Defense-Shot
- ☐ Clearing-Offense
- ☐ Riding-Defense

Un-Settled:

- ☐ Ground Ball/Loose Ball
- ☐ Fast Break Offense
- ☐ Fast Break Offense Shot
- ☐ Fast Break Defense
- ☐ Fast Break Defense Shot
- ☐ Transition Offense
- ☐ Transition Defense
- ☐ Face-Off/ Draw

5. PLAYER ACTITIVY (Check only one):

Shot On Goal:

- ☐ Taking Shot
- ☐ Field Player Defending Shot
- ☐ Goalie Defending Shot

Ball Possesion:

- ☐ Offensive Player w/ Ball
- ☐ Defensive Player Marking
- ☐ Player w/ Ball

Passing:

- ☐ Delivering A Pass
- ☐ Catching A Pass

Off Ball:

- ☐ Off Ball, Offensive Player
- ☐ Off Ball, Defensive Player

Other, Non-Contact:

- ☐ Agility Drill
- ☐ Skill Drills
- ☐ Sprinting
- ☐ Endurance Training
- ☐ Strength Training

6. PLAYER POSITION (Check only one):

- ☐ Attack
- ☐ Midfield
- ☐ Defense
- ☐ Goalie
- ☐ Official/Referee
- ☐ Coach
- ☐ Other Non-Participant

7. LOCATION (Check only one):

- ☐ Playing Offense at Offensive End of the Field
- ☐ Playing Defense at Offensive End of the Field
- ☐ Playing Offense at Defensive End of the Field
- ☐ Playing Defense at Defensive End of the Field
- ☐ Playing Offense in Midfield
- ☐ Playing Defense in Midfield
- ☐ Playing Offense Near the Crease
- ☐ Playing Defense Near the Crease

8. PENALTY (Check only one):

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy 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 (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. Payment under this policy will be made according to **usual and customary guidelines**. This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **90** days from date of injury to submit claim form.
For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.

Benefit Period: This policy is subject to a **104 week** eligibility period from date of injury. Medical or dental expenses that are incurred **within 104 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **104 week** benefit period will not be covered by this policy.

3. **Please Remember:**

a. Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
b. a)Attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
c. **Itemized bills are required:** You must submit itemized bills; balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to you if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.
    1. HCFA-1500 is the standard form used by Providers, such as doctors and dentists, to show the medical treatments and charges made for each service.
    2. UB-04 or UB-92 is the standard form used by Hospitals to show medical treatments and charges made for services.

4. Please be aware of the deductible that will be applied to your claim:

a. Adult Male Players: $2,500.00
b. All Other Players, Coaches and Officials: $500.00

5. Make sure that an authorized official of your local Lacrosse team or league has signed the Claim Form under the "Verification of Covered Activity" (signature #1). The coach, manager or referee who can verify that the injury took place during a sponsored amateur lacrosse activity may sign the form. If this accident occurred during a camp, clinic or tournament, the director or coach or referee who can verify that the claim took place during a sponsored activity must sign the Claim Form. **Do not send the claim to the U.S. Lacrosse National office for verification.**

6. Player Activity Information (Section VI): For the purpose of an injury study being conducted by the Sports Science and Safety Committee, please complete this section to further describe how the injury occurred.

7. **Dental Bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.

8. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.

1. Employer contribution to flex account - Send to Primary insurance first, then flex account, then Bollinger
2. Employee contribution to flex account - Send to Primary insurance first, then Bollinger, then flex account. If monies have been paid out of your flex account before Bollinger then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

For further Claims information contact:

Bollinger Sports Claims
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: Attn Sports Claims 973-921-2876

FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any 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 statement 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: 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 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.

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.

DELAWARE: 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 RESIDENTS: 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

LOUISIANA: 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.

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.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

VIRGINIA: 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.

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.