COMPLETE AND RETURN THIS FORM TO:

Medical/Dental Accident CLAIM FORM

RPS BOLLINGER SPORTS & LEISURE INSURANCE

MARKEL®

P.O. Box 390 Short Hills, NJ 07078

52-week benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

1. **NAME:**(first)_____(last)_____
2. **ADDRESS:**_____(city)_____(state)_____(zip code)_____
3. **TELEPHONE #:** _____
4. **BIRTHDATE:** ____/___/____ **SEX:** Male☐ Female☐ SS#:_____
5. **CLAIMANT IS A:** ☐ Player ☐ Coach ☐Official ☐ Other
6. **ACCIDENT DATE:** __/__/__ **ACCIDENT TIME:**_____ ☐ am ☐pm
7. **BODY PART INJURED:**_____
8. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐Camp/Clinic ☐Other_____
9. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____
_____
10. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURED:**_____

SECTION II STATISTICAL INFORMATION (required)

1.NAME OF TEAM/CLUB:_____

2. TYPE:	☐ Competitive	☐ Recreational		
3. LOCATION:	☐ On Field	☐ Indoor	☐ Spectator Area	☐ Other
4. SURFACE:	☐ Dirt	☐ Grass	☐ Outdoor Turf	☐ Indoor Turf
5. SURFACE CONDITION:	☐ Dry/Normal	☐ Wet/Rainy	☐ Icy	☐ Muddy

6. POSITION: _____

7. STATUS: ☐ HIT BY OBJECT ☐ COLLISION W/OPPONENT ☐ COLLISION W/TEAMMATE

☐ OTHER_____

SECTION III TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL (required)

Policy Effective Date	**Policy Expiration Date**	**Policy #**	**Name of Policyholder**
01-01-2019	01-01-2020	4102AH010204 - 1	United States Gaelic Athletic Associatio

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	TELEPHONE NUMBER
USGAA	MPS 14300 S. RAvinia Ave.,		#200

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

☐ YES-SPONSORED/SANCTIONED ACTIVITY

☐ YES-CLAIMANT WAS AN ACTIVE MEMBER ON THE DATE OF ACCIDENT

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.		
AUTHORIZED SIGNATURE:	**TITLE:**	**DATE:**

SECTION IV STATEMENT OF OTHER INSURANCE (required)

Claimant/Father

Name:_____
Address:_____
City:_____
State:_____ Zip Code:_____
Phone:_____
Employer:_____
Phone:_____
Self Employed ☐ Unemployed ☐
Email: _____

Claimant/Mother

Name:_____
Address:_____
City:_____
State:_____ Zip Code:_____
Phone:_____
Employer:_____
Phone:_____
Self Employed ☐ Unemployed ☐
Email:_____

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**

POLICYHOLDER NAME: _____ ID#: _____

INSURED GRP#/NAME: _____

INSURANCE COMPANY NAME:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE:_____

****Please include copy of insurance card (both sides)**

Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: _____

SECTION V ASSIGNMENT OF BENEFITS (required)

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING PROVIDED INDICATES PAYMENT MADE BY YOU.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (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 RPS Bollinger or Markel Insurance Company or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required): _____ DATE:_____

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR A 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. If you receive Government or State Aid Insurance, (Medicaid, Medicare, etc) this insurance may be Primary; please contact RPS Bollinger for coverage information.

- 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:** In most states, you have up to **1 year** from the date of injury to submit a claim form. For claims to be eligible for coverage, you must seek medical attention within **60 days** from the date of injury.

Benefit Period: This policy is subject to a **52 week** benefit period from the date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**

a) **Only submit the Claim Form to RPS Bollinger.**
b) Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to RPS Bollinger.
c) **Itemized bills are required:** You or your providers must submit itemized bills with your primary insurance explanation of benefits (if applicable); 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.

- **CMS-1500** is the standard form used by Providers to show the medical treatments and charges made for each service.
- **UB-04** is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **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. Please have your provider submit an ADA dental claim form with the explanation of benefits (if applicable).

For further Claims information contact:

RPS Bollinger Sports Claims Department
PO Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-8474
Email: SportsClaims@RPSins.com

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