

**MASSACHUSETTS YOUTH SOCCER ASSOCIATION, INCORPORATED  
EXCESS SOCCER ACCIDENT MEDICAL COVERAGE**

2444 Old Union Turnpike Lancaster, MA 01523

Telephone: (978) 466-8812

***Please read the following directions carefully. Failure to fully and properly complete the claim form will delay the processing of your request for benefit payment under the plan.***

***The Massachusetts Youth Soccer Association, Incorporated (Mass Youth Soccer) self-insures the Excess Soccer Accident Medical program for affiliated players and adults and has ultimate liability for all benefit payments. All payments are made in accordance with the terms and provisions of the plan. Mass Youth Soccer reserves the right to authorize an administrator to act in our capacity in evaluating the payment requests that have been submitted and makes recommendations to us in accordance with the terms and conditions of the plan.***

***The Mass Youth Soccer Excess Soccer Accident Medical program provides coverage only after all other medical plans have made their payments. See Number 5 – Claim Submission Instructions below.***

**CLAIM SUBMISSION INSTRUCTIONS:**

1. Complete **ALL** portions of the Mass Youth Soccer Claim Form except Section III. The Claim Form has eight (8) sections. Failure to complete all sections of the claim form will delay the processing of your claim. The question that pertains to other insurance appearing in Section IV **must be** answered.
2. Have the coach or other club/organization official that witnessed the accident sign the “WITNESS VERIFICATION” in Section II.
3. Signatures are also required in Section V -- “CERTIFICATION STATEMENT”, Section VII – “AUTHORIZATION TO OBTAIN MEDICAL INFORMATION”, and Section VIII – “AUTHORIZATION TO ASSIGN BENEFITS”.
4. File this claim form with the Mass Youth Soccer Office within 90 days of the date of the accident. Do not wait until you have all of your itemized bills for the accident, or until the bills have been processed by your other insurance carrier/provider.
5. The Mass Youth Soccer plan provides “excess” coverage. That means you **must** first submit all of your expenses to your insurance carrier or provider for processing. You will receive an Explanation of Benefit (EOB) form from them explaining what has and has not been covered. The EOB form must be submitted to us before we can process your claim.
6. Attach all bills and all explanation of benefit forms that you have received to the claim form when it is first submitted to Mass Youth Soccer. If you later receive additional bills and/or Explanation of Benefit forms, submit those directly to Mass Youth Soccer as you receive them.

**Remember, you must first send this claim form to Mass Youth Soccer at the above address for signature and eligibility verification.**

## THINGS TO REMEMBER:

1. The Mass Youth Soccer Excess Soccer Accident Medical Plan covers only accidents that result from a sanctioned soccer activity.
2. The Plan has separate deductibles for dental and medical expenses. The deductible applies to all submitted expenses. These are the important deductible and benefit provisions:
  - The deductible for dental expenses is \$100.
  - The deductible for medical expenses is \$250.
  - Eligible accidents are covered for a two year benefit period.
  - The maximum benefit that the plan pays is \$50,000 for any one accident.
  - There are no pre-existing condition limitations.
2. The initial completed claim form, along with any itemized bills and Explanation of Benefit forms, must be sent to Mass Youth Soccer at the address shown on the front of the claim form.
3. Additional bills and Explanation of Benefit forms should be sent directly to Mass Youth Soccer at the address on the front of the claim form. Be sure to include the name of the claimant, date of the accident and indicate that you are a Mass Youth Soccer member.
4. All correspondence or communication to us concerning the status of a claim should include the name of the claimant and the date of the accident.
5. Each itemized bill must show the following:
  - (a) name, address, telephone number and Federal tax i.d. number for the Provider of service;
  - (b) diagnosis code (ICD-9) or diagnosis description for the accident;
  - (c) date of service or treatment;
  - (d) Procedure code(s) (CPT) or Procedure description; and
  - (e) charge for each procedure.
6. Please allow sufficient time to process your claim. To check on the status of your claim, please call the Mass Youth Soccer Office directly using the phone number on the front of the claim form.
7. Please respond promptly to any correspondence requesting additional information. It is the responsibility of the parent or guardian, or of the adult claimant, to request this information from the provider of service or insurance carrier/provider.

A payment worksheet will be sent to you from Mass Youth Soccer describing how your claim request was processed. Mass Youth Soccer will also make any claim payment required to be made under the plan. If you disagree with the payment amount, or if your claim was denied in whole or in part, you should submit a written appeal to Mass Youth Soccer, c/o Executive Director, 2444 Old Union Turnpike, Lancaster, MA 01523. You will receive a written response to your appeal within 30 days of the date it is received.

**EXCESS SOCCER ACCIDENT  
MEDICAL CLAIM FORM**

**MASSACHUSETTS YOUTH SOCCER ASSOCIATION**  
2444 Old Union Turnpike  
(978) 466-8812 – Phone

**Lancaster, MA 01523**  
(978) 466-8817 – Fax

**THIS CLAIM MUST FIRST BE SENT TO MASS YOUTH SOCCER ASSOCIATION FOR VERIFICATION AND  
SIGNATURE AUTHORIZATION  
FAILURE TO FULLY COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE  
PROCESSING OF THIS CLAIM REQUEST.**

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**SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

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CLAIMANT NAME: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ SEX: \_\_\_\_\_

CLAIMANT IS: \_\_\_\_\_ Player \_\_\_\_\_ Coach/Asst. Coach \_\_\_\_\_ Other (Specify) \_\_\_\_\_

ACCIDENT DATE: \_\_\_\_\_ TIME OF INJURY: \_\_\_\_\_

DESCRIBE INJURY . Indicate LEFT or RIGHT; ARM, LEG, etc. (Use last page if needed):

DID ACCIDENT OCCUR (CHECK ALL THAT APPLY): \_\_\_\_\_ Game \_\_\_\_\_ Practice \_\_\_\_\_ Tournament  
\_\_\_\_\_ Indoor Soccer \_\_\_\_\_ MYSA Sanctioned/Sponsored Event \_\_\_\_\_ Travel To or From Activity or Site

DESCRIBE COMPLETELY HOW AND WHERE ACCIDENT OCCURRED (Use last page page if needed):

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**SECTION II WITNESS VERIFICATION – SIGNATURE REQUIRED**

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\_\_\_\_\_  
Signature of Person Witnessing Injury      Witness Name (print) / Relationship to Claimant      \_\_\_/\_\_\_/\_\_\_  
Date

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**SECTION III TO BE COMPLETED BY AUTHORIZED MASS YOUTH SOCCER ASSOCIATION OFFICIAL**

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*THIS FORM MUST BE SENT TO MYSA FOR VERIFICATION & SIGNATURE AUTHORIZATION BEFORE THE  
CLAIM FORM WILL BE PROCESSED.*

I, \_\_\_\_\_, certify that the above claimant was a registered player, coach or  
other registered member of the Massachusetts Youth Soccer Association at the time the accident occurred.

\_\_\_\_\_  
Signature of Authorized Official      Title      \_\_\_/\_\_\_/\_\_\_  
Date

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**SECTION IV****PARENT / GUARDIAN / ADULT CLAIMANT INFORMATION**

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*Father/Male Guardian/Male Claimant*

Name: \_\_\_\_\_  
S.S.#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_

*Mother/Female Guardian/Female Claimant*

Name: \_\_\_\_\_  
S.S.#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_

*Is Claimant Covered By Any Other Insurance Policy:* \_\_\_\_\_ No \_\_\_\_\_ Yes (If yes, complete below)

Insurance Company/Provider Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Group or Policy Name: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Insured's I.D. Number: \_\_\_\_\_

If your son or daughter is the claimant and has medical insurance or coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please provide the name, address and phone number of the person responsible for providing the insurance or coverage:

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**SECTION V****CERTIFICATION STATEMENT**

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***I certify that, to the best of my knowledge, the statements and answers appearing in this claim form are true and complete.***

Signature of Parent/Guardian/Adult Claimant: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**SECTION VI****CLAIM STATISTICAL INFORMATION**

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1. CLAIMANT NAME: \_\_\_\_\_ 2. SEX: Male: \_\_\_ Female: \_\_\_  
3. CLUB OR ORGANIZATION AFFILIATION: \_\_\_\_\_  
4. TEAM NAME: \_\_\_\_\_ 5. LEAGUE: \_\_\_\_\_  
6. COMPETITIVE: \_\_\_\_\_ 7. RECREATIONAL: \_\_\_\_\_ 8. AGE DIVISION (U-10, U-8, etc): \_\_\_\_\_  
9. DISPOSITION: \_\_\_ On Site Care \_\_\_ Ambulance \_\_\_ Personal Transportation  
10. LOCATION: \_\_\_ On Field \_\_\_ On Sidelines \_\_\_ Spectator Area \_\_\_ Other  
11. SURFACE: \_\_\_ Grass \_\_\_ Dirt \_\_\_ Artificial Surface (outdoor) \_\_\_ Indoor  
12. POSITION: \_\_\_ Goalie \_\_\_ Defender \_\_\_ Midfielder \_\_\_ Forward \_\_\_ N/A  
13. CAUSE: \_\_\_ Hit by Ball \_\_\_ Collision \_\_\_ Non-Contact Injury \_\_\_ Other

*If necessary, please attach additional information to fully describe cause and nature of injury.*

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**SECTION VII****AUTHORIZATION TO OBTAIN MEDICAL INFORMATION**

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**To all physicians, medical professionals, hospitals, clinics, other health care providers, insurers, employers, group policyholders, insurance support organizations and other persons who have information about the Claimant:**

**I authorize you to give to the Massachusetts Youth Soccer Association, Incorporated (MYSA), its reinsurers or agents: (a) all information you have as to the injury, medical history, diagnosis, treatment and prognosis With respect to the physical condition of the Claimant; (b) all information you have with respect to other medical insurance or coverage applicable to the Claimant; and (c) any other information you have about the Claimant which MYSA believes it needs to perform the functions described below.**

**The information obtained will be used (a) to determine if the Claimant is eligible under the MYSA medical plan of benefits; (b) to determine the level of benefits to be payable if the Claimant is eligible; and (c) for any other purpose which relates to the operation of the plan.**

**This authorization will be valid as long as the claim lasts, but not beyond two years from the date below. I know that I may request a copy of this form. I agree that a photocopy is as valid as the original.**

Parent/Guardian/Adult Claimant Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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**SECTION VIII****AUTHORIZATION TO ASSIGN BENEFITS**

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I authorize all eligible payments to be made to: \_\_\_ Provider of Medical Services \_\_\_ Self \_\_\_ Other (if other, please specify):

Parent/Guardian/Adult Claimant Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## **ADDITIONAL INFORMATION**

*Please indicate the Section to which any following information applies:*