

# **Rocky River Soccer Organization**

**March 2015**

## **Risk Management Policies, Procedures and Programs Including:**

**Insurance Information**

**Insurance Claims Forms**

**Insurance Policy Summary**

**Incident Report**

**Possible Concussion Notification**

In an effort to protect players, coaches, managers, the board of directors and other soccer volunteers, the Rocky River Soccer Organization (RRSO) has implemented a number of coverages and programs to respond to issues and events that may arise during the year,

First, RRSO maintains two policies to protect its members and participants. One policy is a commercial general liability policy and the other is a blanket accident and health policy special risk. These policies are underwritten by Markel Insurance Co. A brief summary of each follows later in this report.

By virtue of RRSO's affiliate membership in Ohio Youth Soccer Association-North (OYSAN) and in the Ohio Travel Soccer League (OHTSL) from them, RRSO is also provided secondary medical and general liability coverages from them. However, those coverages do not extend to RRSO's Icebreaker Indoor Tournament, its' Soccer Jamboree and other events not sanctioned or endorsed by OYSAN and OHTSL. Hence, there is some duplication of coverages. An explanation of both coverages provided by OYSAN and OHTSL follows later in this report as well.

In addition, in 2005 RRSO in conjunction with its insurance carrier, Markel Insurance Company, adopted a crisis management program for sexual abuse and misconduct. The report outlining the action steps to be followed in the event such an incident occurs can be found on the RRSO website at [rrso.org](http://rrso.org).

In a related way, OYSAN and OHTSL have implemented an extensive risk management system. These programs are designed to create a safe environment for all players associated with OYSAN and OHTSL. Access to this risk management system can be found on the OYSAN web site at [oysan.org](http://oysan.org) or on OHTSL's web site at [ohtsl.com](http://ohtsl.com).

Coaches and managers are RRSO's first line of defense when injuries, illnesses, abuse or misconduct arise. It is important that you become familiar with RRSO's insurance coverages and crisis management program as well as OYSAN's insurance coverages and OHTSL's insurance plans..

Should any of these incidents arise it is important that you act in a responsible way to minimize the impact of the event, gather the appropriate information on the incident and report the incident to the proper authorities and officials of RRSO, OYSAN or OHTSL. The following individuals should also be contacted:

**For RRSO:**

**Submitting Incident Report:**

**Crisis Management including Sexual Abuse and Misconduct**

RRSO President: Mike Moore  
Home phone: (440) 331-6167  
Cell phone: (440) 915-6167  
E-mail: [president@rrso.org](mailto:president@rrso.org)  
270 Buckingham  
Rocky River, Ohio 44116

**For OYSAN:**

**Risk Management**

Jessica Chambers  
E-mail: [jchambers@ohionorthsoccer.org](mailto:jchambers@ohionorthsoccer.org)

**Insurance Claims - RRSO**

RRSO Agent: Gary Lanzen  
Home phone: (440) 356-0912  
Office phone: (216) 696-3000  
Fax: (216) 621-7336  
E-mail: [lanzen@sbcglobal.net](mailto:lanzen@sbcglobal.net)  
21395 Morewood Pkwy.  
Rocky River, Ohio 44116

**Insurance Claims – OYSAN**

(Academy girls and boys)  
Bernie Telmanik  
E-mail: [btelmanik@ohionorthsoccer.org](mailto:btelmanik@ohionorthsoccer.org)  
6550 W. Snowville Road Suite Y  
Brecksville, Ohio 44141  
Phone: (440) 526-9020 ext. 202  
Fax: (440) 526-9055

**Insurance Claims OHTSL (girls & boys)**

US Club Soccer – Youth  
716 8th Avenue North  
Myrtle Beach, South Carolina 29577  
E-mail:  
[insurancequestionseusclubsoccer.org](mailto:insurancequestionseusclubsoccer.org)  
Or contact:  
NAHGA Claims Services  
PO Box 189  
Bridgton, Maine 04009-0189  
Phone: 1 (800) 952-4320  
Fax: (207) 647-4569

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### Incident Instructions / Procedures

1. If an incident occurs complete incident report and submit to RRSO President – Mike Moore
2. If a claim needs to be submitted, review coverage summaries and determine who to file it with.
3. If it is an accident / sickness or health claim and you are a :
  - a. U-8 Academy player or coaches of – submit to Markel and / or OYSAN
  - b. U-9 to U-14 player or coach of – submit to Markel and / or US Club Soccer

## **Rocky River Soccer Organization Insurance Summary**

**Policyholder:** Rocky River Soccer Organization (RRSO)

**Policy Period** From 01-01-2015 to 01-01-2016

**Commercial General Liability Policy**

**Policy Number:** 8502AH380252-3

This insurance is limited to bodily injury, property damage and personal and advertising injury arising out of the conduct of operation or conduct of soccer activities by team members, managers, coaches, assistants, directors, officers, referees, officials, sponsors and other individuals participating in the official function of RRSO. This policy is also endorsed to pay damages that result in bodily injury, personal injury or advertising injury because of sexual abuse, molestation or exploitation arising from negligent hiring, training and supervision practices. The occurrence limit of liability on this policy is \$1,000,000.

### **Blanket Accident and Health Policy Special Risk**

**Policy Number:** 4102AH249529-12

All registered participants and volunteers are covered for injury resulting from an accident which occurs directly from: (1) activities that are scheduled, sponsored or supervised by RRSO; (2) premises owned, leased or borrowed by RRSO; or (3) travel scheduled, sponsored or supervised by RRSO. Accident does not include a loss due to or contributed by disease or sickness. Such insurance as is afforded by this policy for accident medical is payable in excess of any expenses payable by other valid and collectable insurance. This is a summary only. One should consult the policy declarations, special policy conditions, forms, exclusions and endorsements that make up the complete policy for further details. The benefit per person limits on this policy are as follows:

Aggregate maximum benefit amount is \$25,000

Deductible amount is \$250.

Coinsurance percentage is 100%

Benefit period is up to 52 weeks.

Accidental death and dismemberment benefit is a principal sum of \$5000.

## **How to File an Accident Claim with the Rocky River Soccer Organization**

1. Notice of claim (statement of claim or claim form) must be given to Markel Insurance Company within 30 days after loss occurs or as soon thereafter as possible. The notice can be given to Markel at PO Box 2039, Glen Allen, Virginia 23058-2039. Notice should include the person's name and the policy number **4102AH249529**.
2. Since Markel Insurance Company has a third party administrator (tpa) to administer and process claims, your completed claim form (policyholder report) should be mailed, faxed or e-mailed to Health Special Risk (HSR). Their phone number is: (888) 765-7223 with the rest of their contact information appearing on the top of the claim form.
3. If you have other insurance, which would be primary, submit your itemized bills to the other carrier first. You will receive a payment Explanation of Benefits (EOB) from your primary carrier. Do **NOT** wait until your primary carrier has processed all of your bills before filing your claim form with Markel / HSR, Inc.
4. You may attach itemized bills and your primary carrier's EOB that are ready at the time of submitting this claim.
5. You should continue to send your itemized bills from your primary carrier to Health Special Risk as you receive them. Do not hold on to them, this will only slow down your claim payment.
6. The RRSO accident medical plan as well as the OYSAN and OHTSL medical plans are written on an excess basis. This means that you must first submit all of your medical bills to your primary insurance carrier (unless you do not have one) for processing. If you are submitting your claim to any of the secondary carriers listed above, they will typically pay the claim applying the principle of coordination of benefits. This means they should split the claim 50 / 50 subject to any policy limitations.
7. Always provide copies of fully itemized medical bills which show the patient's name, date of service, the type of service rendered, the diagnosis or nature of the condition being treated and the provider's name and address. You should provide all appropriate EOB's. Please retain copies of all correspondence for your records.
8. The policy provisions require the carrier to send the insured any further proof of loss forms within 15 days of its receipt of your Notice of Claim.
9. Any required written proof of loss must be given to the carrier by you within 90 days after such loss.

10. The carrier is to immediately pay all benefits as they accrue.

### **Frequently Asked Questions**

#1.

Q. What is the purpose of RRSO's risk management program?

A. The purpose is to make coaches, volunteers and parents aware of the programs RRSO has put in place to manage risk and injuries in our soccer organization.

#2.

Q. What is the reason for the incident report?

A. The report was established to assist coaches in facilitating and communicating any incident to the RRSO Board of Directors that requires RRSO's attention and follow up as this impacts the safety and well being of all participants in the RRSO soccer program.

#3.

Q. What insurance coverages are provided by RRSO?

A. RRSO maintains a general liability policy to protect those individuals who participate in an official function of RRSO. This would include people such as coaches, managers, and directors / officers. RRSO carries an accident and special risk health policy for those participants and volunteers in RRSO. These insurances extend coverage to each RRSO sponsored event.

#4.

Q. Why are there similar insurance coverages provided by the Ohio Youth Soccer Association – North (OYSAN) for U-8 Academy and the Ohio Travel Soccer League (OHTSL) for U-9 through U-14?

A. By virtue of RRSO's participation in soccer leagues sanctioned by OYSAN and OHTSL, we receive automatically general liability benefits, accident medical expense benefits and accidental death and dismemberment benefits. Although these coverages may duplicate RRSO's own insurance plans, they do afford our participants a second source to address their appropriate insurance claims. However, the OYSAN and OHTSL policies only address claims that arise from events they sanction.

#5.

Q. What process should I follow if I have a medical claim?

A. Assuming you have your own medical insurance, you should always submit the claim to this carrier first since they are deemed to be primary. Once you have received your Explanation of Benefits from your carrier or within 30 days, whichever occurs first, then you may wish to submit the balance of the claim to either one or both of the

medical insurance carriers insuring RRSO, OYSAN for U-8 Academy and OHTSL for all U-9 through U-14. These are deemed to be secondary.

#6.

Q. Who should I contact with a risk management question or concern?

A. If you are submitting an incident report, you should e-mail or fax the report to the President of RRSO. Currently that is Mike Moore whose e-mail address is [president@rrso.org](mailto:president@rrso.org). For insurance claims or questions you should contact Gary Lanzen by e-mail at [lanzen@sbcglobal.net](mailto:lanzen@sbcglobal.net) or by phone at (216) 696-3000 ext. 236. If this pertains to a claim submission to OYSAN then contact Bernie Telmanik at OYSAN by e-mail at [btelmanik@ohionorthsoccer.org](mailto:btelmanik@ohionorthsoccer.org) ; by phone (440) 526-9020 ext 202 ; or by fax: (440) 526-9055. If it is for OHTSL call NAHGA Claims Services at 1 (800) 952-4320.



Return Completed form to:  
 Health Special Risk, Inc.  
 HSR Plaza II; 4100 Medical Parkway  
 Carrollton, TX 75007  
 P: 888-765-7223 / F: 972-512-5820  
 Markelclaims@hsri.com

# Special Risk Claim Form

### Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number above.

\*\*In order to pay claims we must have your Social Security Number\*\*

### Part 1- POLICYHOLDER'S REPORT

Name of School	Name of Policyholder <b>Rocky River Soccer Organization</b>	Policy Number <b>4102AH249529 - 12</b>		
Claimant's Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		
Social Security Number (Required)	Email Address			
Claimant's Address	City	State	Zip	Phone Number
Parent's Name (if applicable)	Parent's Address (if applicable)	City	State	Zip
				Phone Number

1. Date and time of accident: \_\_\_\_\_ Place where the accident occurred: \_\_\_\_\_
2. Was the injured person:  Participant  Staff Member  Guest  Volunteer
- FOR DENTAL CLAIMS ONLY
3. Indicate which teeth were involved in the accident: \_\_\_\_\_
4. Describe condition of injured teeth prior to accident:  Whole, Sound, and Natural  Filled  Capped  Artificial
5. Nature of Injury: \_\_\_\_\_  
(Indicate part of body injured- e.g. broken arm, sprained ankle, etc.)
6. Describe how the accident occurred- give all possible detailed- must be a bodily injury due to accident: \_\_\_\_\_
7. Did the accident occur?
 

A. During a policyholder sponsored & supervised activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. During programmed hours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. On activity premises?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. While traveling directly to or from a sponsored event?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. During a USGF sanctioned event (Gymnastics schools only) or competition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Name of the event or activity: \_\_\_\_\_ Name and Title of Supervisor: \_\_\_\_\_
9. Representative Signature \_\_\_\_\_ Title \_\_\_\_\_ Date: \_\_\_\_\_

### Part 2- OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health coverage through an employer or other source?  Yes  No  
 If Yes, Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_  
 Is the Claimant enrolled as an individual, employee or dependent member of one of the following:  
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of  
 accident/health/sickness plan?  Yes  No  
 If Yes, Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_  
**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE OR HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**  
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse Markel Insurance Company to the extent of any amount collectible.

Claimant, Parent or Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to the insured.

Claimant, Parent or Authorized Representative s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Authorized Representative, Relationship to Patient or Legal Designation: \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC 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. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Authorized Representative, Relationship to Patient or Legal Designation: \_\_\_\_\_



**YOUTH SOCCER  
GENERAL LIABILITY BENEFITS**  
Explanation of Coverage  
Term of Insurance: September 1, 2014 to September 1, 2015

**ACCIDENT MEDICAL EXPENSE BENEFITS &  
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**  
Explanation of Coverage  
Term of Insurance: September 1, 2014 to September 1, 2015

**Who is Covered?**

Ohio Youth Soccer Association - North, its affiliated associations, leagues, clubs and all officers, directors, coaches, employees, teams, team officials, and volunteers while acting on behalf of Ohio Youth Soccer Association - North at a covered activity.

**Limits of Liability**

- General Aggregate NONE (Unlimited)
- Products/Completed Operations Aggregate \$1,000,000
- Personal and Advertising Injury \$1,000,000
- Each Occurrence \$1,000,000
- Participant Legal Liability Each Occurrence (other than brain injury) \$2,000,000
- Participant Legal Liability Aggregate (other than brain injury) Unlimited
- Participant Legal Liability Brain Injury Each Occurrence \$2,000,000
- Participant Legal Liability Brain Injury Aggregate \$5,000,000
- Damage to Premises Rented to You Limit \$300,000
- Medical Expense (Spectators Only) \$5,000
- Sexual Abuse Each Occurrence \$1,000,000
- Sexual Abuse Aggregate \$2,000,000
- Non-Owned / Hired Auto Liability \$1,000,000
- Stop Gap Liability Each Accident \$1,000,000
- Stop Gap Liability By Disease Aggregate \$1,000,000
- Stop Gap Liability Disease Each Employee \$1,000,000
- Excess Liability \$5,000,000 subject to policy exclusions

**Who is Covered?**

Insured persons include all registered team members, those players participating in approved try-outs, coaches, managers, referees, officials, and volunteers of the teams, leagues or of the association.

**Covered Activities**

Insured persons are covered for injuries resulting directly and independently of all other causes from accidents occurring while participating in the following covered activities:

- Scheduled games, team practice sessions, tryouts or sponsored activities provided they are under the direct supervision of a team official, or sanctioned local or national tournaments as a member of a contestant team.
- Organized and supervised group travel as authorized by the Policyholder directly to and from a covered event.

**What is Not Covered**

The plan does not provide coverage for:
 

- intentionally self-inflicted injury
- air travel except as a fare-paying passenger on a regularly scheduled airline on a scheduled flight
- injuries resulting from other than covered activities
- loss resulting from sickness or disease, except bacterial infection which occurs through an accidental wound

**Accident Medical Policy Limits**

For reasonable necessary medical expenses, our youth accident medical policy pays up to \$100,000 for injuries sustained in a covered accident. Dental injuries are treated like any other injury. Payment will not be made for any expenses incurred after 104 weeks from the date of injury. An expense is considered incurred on the date the medical care is rendered. A \$500 Deductible applies to each covered accident.

**Ohio Youth Soccer Association - North excess accident medical insurance policy is secondary insurance. Failure to follow the rules of your primary healthcare coverage will result in a benefit reduction of eligible expenses to 50% of the amount otherwise payable.**

**What is Covered?**

- Liability for bodily injury or property damage to spectators, game participants, and to members of the general public for activities sanctioned by Ohio Youth Soccer Association - North.
- Liability for outdoor fields owned by affiliates for its sole use while acting on behalf as a member of the state association.
- Fundraising, meetings, awards banquets.
- Activities necessary or incidental to the conduct of practice, exhibition, post season and scheduled games.
- Liability for false arrest, detention or malicious prosecution, libel, slander, defamation of character, or wrongful eviction.
- Hired and non-owned auto, while being used in the business of the named insured. Excludes coverage for any driver transporting athletic participants.
- Products liability for food or drinks sold on premises.
- Medical Payments \$5,000 (non-participants).
- Host Liquor liability for banquets and meetings.

**Territory**

Worldwide for bodily injury, property damage, and personal and advertising injury while temporarily outside of the United States providing suit is made within the United States.

**Notable General Liability Exclusions**

- Standard commercial general liability exclusions apply.
- Property of others in the care, custody and control of the insured such as personal property of players, coaches, or parents.
- Liability to pay Worker's Compensation.
- Intentional acts.
- Amusement devices other than inflatables and dunk tanks.

**Additional Insured**

Certificates of insurance are furnished to each association identifying them as members of the state organization. Certificates of insurance will be issued upon request adding the name of a school district, university, private land owner, municipality, or sponsor. All other requests are subject to underwriting approval.

"Injury" means bodily injury of an Insured Person resulting directly and independently of all other causes from an accident which occurs while he or she is participating in a covered activity. Sickness or disease (except pus forming infections which occur through an accidental cut or wound) of any kind will not be considered as bodily injury.

Reasonable Expenses means usual and customary charges.

**Accidental Death and Dismemberment Benefits**

- The plan pays:
- \$5,000 for loss of life or loss of two or more members, which results from injuries sustained in an accident which occurred while participating in a covered activity.
  - \$2,500 for loss of one member (hand, foot or eye), which results from injuries sustained in an accident which occurred while participating in a covered activity.
  - Such payment shall be in addition to any other indemnity payable to the date of loss, but only one amount, the larger amount applicable shall be payable for all such losses resulting from any one accident.
  - "LOSS" shall mean, with respect to hands and feet, physical separation through or above the wrist or ankle joint; with respect to the eyes, entire and irrecoverable loss of sight.

**Excess Coverage**

The participant accident medical expense insurance is provided on an "excess" basis. This means that after the insured player or coach has been reimbursed for medical expenses by other insurance programs, and after the deductible has been satisfied, the Youth Soccer Accident Medical Expense plan will pay up to the maximum Medical Expense benefit for remaining treatment, service and supply expenses. These other programs include group, blanket or franchise health insurance coverage, group hospital or medical service plans, and prepayment coverage; any coverage under labor-management trustee plans, union welfare plans, employer organization plans, and coverage under any governmental programs, coverage required or provided by any statute, and automobile reparations insurance (no-fault) coverage.

**Claim Procedures**

For AD&D and Accident Medical Expense Claims, claim forms are available through your State Soccer Association, League or Club Offices. Detailed Accident Medical Expense claim instructions can be found on each claim form. In the event of injury requiring medical treatment, you should:

- Fully complete a claim form verified by a witness and submit it to your State Soccer Association for verification.
- Notice of claims must be filed within 90 days from the date of injury or as soon thereafter as is reasonably possible.

Youth Soccer Accident Medical coverage is provided on an "excess" basis. Therefore, charges must first be submitted to any other medical insurance carrier available to the participant.



## Ohio Youth Soccer Association North

### Insurance

#### Insurance Claim Checklist

1. Claimant must be registered at the time the injury took place.
2. Claimant's injury must have taken place on an insured field location.
3. Report of the injury must be received by the State Office either by phone or email within 48 hours.
4. Claim form, verified by a witness, must be submitted and received by Ohio North for verification no later than 60 days from date of injury.
5. \$500 deductible applies for all eligible claims.
6. Include a copy of Permission to Travel approval (if injury took place outside Ohio North)

All injuries from Ohio North or US Youth Soccer activities must be reported to both the member organization and Ohio North via phone or email with 48 hours. All claims are required to first be made through member's primary insurance carrier prior to being submitted to Ohio North. The Ohio North Youth Soccer Association excess accident medical insurance policy is secondary insurance. Failure to follow the rules of your primary healthcare coverage will result in a benefit reduction of eligible expenses to 50% of the amount otherwise paid. Any claims not submitted to Ohio North with 60 days will be denied.

For insurance claims, contact [Bernie Telmanik](#).

#### Indoor Insurance

Indoor protection is now provided if:

- An Ohio North affiliated league (where players are already registered to teams) reports, in writing to Ohio North, sanctions or endorses indoor team participation
- An Ohio North affiliated league hosts or coordinates indoor training, games, practices, scrimmages, etc.
- Ohio North affiliated leagues must request insurance certificates online from Ohio North in advance of player and/or team indoor participation.
- Coaches, Assistant Coaches, Team Managers, and other Team Officials must be registered with Ohio North and must have a valid background check on file with Ohio North.

#### Insurance Forms and Resources

- [Ohio North Insurance Claim for Injuries](#)
- [D&O Policy Information](#)
- [Insurance Outline Form](#)

## Youth Soccer Accident Medical Claims Process Overview

The accident medical policy provided by your state soccer association is an excess / secondary policy. If you have other valid and collectable primary insurance, all charges must first be submitted to your primary insurance carrier.

The online claims submission program is for accident dates on or after September 1, 2011. If your accident date was before this date, DO NOT PROCEED WITH THE ONLINE SUBMISSION OF THE CLAIM; instead, you must use the paper claim form found [here](#).

### Online Claims Submission Process

- 1) The claimant (injured person) or parent / legal guardian (if claimant is under the age of 18) should complete the online claim form on this website. A confirmation email will be sent to you upon completion.
- 2) The claims information will be sent to your state soccer association for approval or denial. Once approved, you will receive an email with the claim form as a PDF attachment. You will need to send the claim form to the insurer with the itemized medical provider bills and explanation of benefits (EOB) from your primary carrier (if applicable). If your claim was denied by the state soccer association, you will receive an email indicating the reason for the denial.
- 3) Additional bills and EOBs can be submitted at a later date (after the initial submission of your claim) to the insurer. Your claim form will have their contact information on it.

## Youth Soccer Accident Medical Claim Form

Attention: This claim form should only be completed by the claimant (injured person) or parent / legal guardian (if claimant is under the age of 18). No other person(s) are authorized to initiate a claim form.

**Fraud Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.



Type the text

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\*\*\*By logging into this system you certify that you are the claimant or the claimant's parent / legal guardian (if claimant is under the age of 18) and you have read the above fraud warning\*\*\*

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General Insurance Information Overview

## U.S. Club Soccer - Youth

### GENERAL INSURANCE INFORMATION

As a benefit of membership, soccer players, coaches, officials and other registered members receive the protection of Bollinger's Soccer Insurance Program for their soccer activities.

#### Who is Covered?

Under the **General Liability** policy, the following are covered as Named Insureds: the Association and its member teams and leagues; all registered players and players participating in try-outs (7 consecutive days or fewer); ; all member coaches and officials; volunteers of the team or league and other participants affiliated with the Association.

The **Accident Policy** covers: all registered players and players participating in try-outs (7 consecutive days or fewer); member coaches and officials; volunteers and other participants directly affiliated with the Association.

### Covered Activities

Registered members and volunteers are covered when participating in the following covered activities:

- Scheduled games, team practice sessions and sponsored activities, provided that they are under the direct supervision of a team official; or tournaments sanctioned by the Association, as a member of a contestant team.
- Group travel directly to or from such scheduled practices, games or sponsored activities is covered under the Accident policy. The Liability policy provides Hired/Non-owned auto liability only for the official business of the Association.
- No coverage is provided under the Liability policy for parents, coaches or volunteers using any automobile to transport team members or volunteers to any practice, game or activity.

### YOUR MENU ITEMS

- [General Information](#)
- [Accident Insurance](#)
- [Liability Insurance](#)
- [Claims Information](#)
- [Purchase Insurance](#)
- [Administrators](#)

U.S. Club Soccer - Youth  
 716 8th Avenue  
 Myrtle Beach, SC 29577  
 Ph: 843-429-0006  
[www.usclubsoccer.com](http://www.usclubsoccer.com)



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Liability Insurance Coverage Overview

## U.S. Club Soccer - Youth

### Who is Covered?

The Soccer Association, its member teams, leagues and clubs, and its member players, coaches and officials are all Named Insureds under this policy with respect to operations and sponsored activities of the Soccer Association.

**Underwriting Carrier:**  
Scottsdale Insurance

**2015 - 2016**

Limit of Liability - per occurrence	<b>\$1,000,000</b>
Limit of Liability - policy aggregate per location	<b>Unlimited</b>
Participants Legal Liability	<b>\$1,000,000</b>
Products/Completed Operations aggregate	<b>\$1,000,000</b>
Personal injury/Advertising injury limit	<b>\$1,000,000</b>
Sexual Abuse Liability limit - per occurrence	<b>\$1,000,000</b>
Hired/Non-owned Auto Liability (official business of Association only)	<b>\$1,000,000</b>
Fire Legal Liability	<b>\$100,000</b>
Medical Expense (non-participants)	<b>(to\$5,000)</b>
Deductible	<b>\$0</b>

*This is a summary of the policy benefits, terms and conditions, and does not alter, broaden or limit coverage in any way.*

### What is Covered?

1. All operations of the Named Insured Soccer Association
2. Claims for liability or negligence for bodily injury or property damage arising out of sponsored activities, premises or operations of the association, its member teams and leagues and participants.
3. Liability for Personal or Advertising Injury, including false arrest, detention or malicious prosecution, or violation of right to privacy.
4. Hired/Non-owned auto liability is provided only for the official business of the Association.
5. No coverage is provided for parents, coaches or volunteers using any automobile to transport team members or volunteers to any practice, game or activity. Teams and leagues can purchase Excess Hired/Non-owned Auto Liability for their activities. Please click on "Purchase Insurance" for details.

### Certificates of Insurance

Liability certificates of insurance will be issued on behalf of member teams and leagues to facility and field owners who need proof of coverage. Requests should be sent to the association office who will process your request in conjunction with Bollinger.

**Liability Exclusions:** The usual Standard Commercial General Liability policy exclusions apply, such as Worker's Compensation, Nuclear Energy, Pollution and Lead; also, use of trampolines and fireworks is excluded.

### YOUR MENU ITEMS

- [General Information](#)
- [Accident Insurance](#)
- [Liability Insurance](#)
- [Claims Information](#)
- [Purchase Insurance](#)
- [Administrators](#)

U.S. Club Soccer - Youth  
716 8th Avenue  
Myrtle Beach, SC 29577  
Ph: 843-429-6006  
[www.usclubsoccer.com](http://www.usclubsoccer.com)



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Accident Insurance Information Overview

## U.S. Club Soccer - Youth

### ACCIDENT INSURANCE PLAN DESCRIPTION for the 2015 - 2016 policy term

This policy provides coverage for accidental injuries incurred by Insured Persons, while participating in Covered Activities of the soccer association.

Underwriting Carrier: Market

**Policy Limits**

Accident Medical/Dental Maximum	\$100,000
Accidental Death & Dismemberment	\$5,000
Deductible per claim	\$500
Physical Therapy/Chiropractic benefit	\$50/\$2,000 maximum limit per visit
Co-Insurance	80/20
Benefit Period	52 weeks from date of injury

**Full Excess Coverage \***

\*This is a Full Excess policy. This insurance is payable in excess of any other valid and collectible Health Plan or insurance in force at the time of the accident causing injury.

The deductible will apply to each covered accident. To be eligible for coverage, medical and/or dental expenses must be incurred within the Benefit Period.

**What is not Covered?**

Some of the types of losses or expenses not covered by this plan are: Dental expense, except for treatment resulting from injury to natural teeth; suicide or self-inflicted injury; eyeglasses or hearing aids; injury due to participation in a riot; injury resulting from declared or undeclared war; cosmetic surgery, except for reconstructive surgery as a result of the accidental injury; infection, except pyogenic or bacterial infection as a result of the accidental injury; travel in any aircraft except as a fare-paying passenger on a commercial aircraft; injury that is eligible for coverage under workers compensation; being intoxicated or under the influence of drugs or narcotics; and claims occurring while hang-gliding or parachuting.

This is only a summary of the policy benefits, terms and conditions, and does not alter, broaden or limit coverage in any way.

**YOUR MENU ITEMS**

- [General Information](#)
- [Accident Insurance](#)
- [Liability Insurance](#)
- [Claims Information](#)
- [Purchase Insurance](#)
- [Administrators](#)

U.S. Club Soccer - Youth  
716 8th Avenue  
Myrtle Beach, SC 29577  
Ph: 843-429-0006  
[www.usclubsoccer.com](http://www.usclubsoccer.com)



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## HOW TO FILE A CLAIM: INSTRUCTIONS

A Medical Claim form, Insurance Claim Verification form, and a Verbal Verification must all be completed before the claim is forwarded to Bollinger Insurance for processing.

### 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. If you receive Government or State Aid Insurance, (Medicaid, Medicare, etc) this insurance may be Primary; please contact 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:** You have **90 days** up to 1 year 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 and **180 days** to seek treatment for dental injury.

**Benefit Period:** This policy is subject to a **52 week** eligibility period from 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.

Send completed form to:  
**US Club Soccer - Claims Dept.**  
716 8th Avenue North  
Myrtle Beach, SC 29577  
Email: insurancequestions@usclubsoccer.org

### 3. Please Remember:

- Only submit the Claim Form to US Club**
- Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to NAHGA
- 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).



Send completed form to:  
**US Club Soccer - Claims Dept.**  
716 8th Avenue North  
Myrtle Beach, SC 29577  
Email: insurancequestions@usclubsoccer.org

For Further Claims Information Contact:  
**NAHGA Claims Services**  
P.O. Box 189  
Bridgton, Maine 04009-0189  
Phone: 1-800-952-4320  
Fax: 207-647-4569



Deductible: \$500 Co-insurance: 80/20

52 week eligibility period

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

1. NAME: (first) \_\_\_\_\_ (last) \_\_\_\_\_

2. ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

3. PHONE: \_\_\_\_\_

4. BIRTHDATE: \_\_\_\_\_ GENDER:  Male  Female SS#: \_\_\_\_\_

5. CLAIMANT IS A:  PLAYER  COACH  OFFICIAL  OTHER

6. ACCIDENT DATE: 1/1/2015 ACCIDENT TIME: \_\_\_\_\_

7. BODY PART INJURED: \_\_\_\_\_

8. ACCIDENT OCCURRED DURING:  GAME  PRACTICE  TOURNAMENT  CAMP/CLINIC

9. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:  
 \_\_\_\_\_

**SECTION II STATISTICAL INFORMATION (REQUIRED)**

1. NAME OF TEAM/CLUB/LEAGUE: \_\_\_\_\_

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 WITH OPPONENT  COLLISION W/TEAM MATE  
 OTHER

**SECTION III TO BE COMPLETED BY U.S. CLUB SOCCER - YOUTH (REQUIRED)**

POLICY EFFECTIVE DATE 1/1/2015	POLICY EXPIRATION DATE 1/1/2016	POLICY # 4102AH008746	NAME OF POLICY HOLDER U.S. Club Soccer - Youth		
ADDRESS OF POLICY HOLDER (STREET) 716 8th Avenue		(CITY) Myrtle Beach	(STATE) SC	(ZIP) 29577	PHONE NUMBER 843-429-0006
VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT. <input type="checkbox"/> YES-SPONSORED/SANCTIONED ACTIVITY <input type="checkbox"/> YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT					
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. AUTHORIZED SIGNATURE: _____			TITLE: _____	DATE: _____	



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

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
EMPLOYER PHONE: \_\_\_\_\_

EMPLOYED  SELF-EMPLOYED  UN-EMPLOYED

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

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
EMPLOYER PHONE: \_\_\_\_\_

EMPLOYED  SELF-EMPLOYED  UN-EMPLOYED

(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: \_\_\_\_\_

INSURANCE 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 V ASSIGNMENT OF BENEFITS**

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 PARENT/GUARDIAN/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 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 PARENT/GUARDIAN/CLAIMANT (REQUIRED): \_\_\_\_\_ DATE: \_\_\_\_\_

Once the Claimant has completed and submitted the *Medical Claim form*, US Club Soccer must verify the claim. A coach, asst. coach, or club official, who was present at the time of injury, must complete and submit an *Insurance Claim Verification form*. Upon receipt, a *Verbal Verification* will be done by US Club Soccer before the claim will be forwarded to Bollinger Insurance for processing.

**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. If you receive Government or State Aid Insurance, (Medicaid, Medicare, etc) this insurance may be Primary; please contact 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:** You have up to 1 year 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 and **180 days** to seek treatment for dental injury.

**Benefit Period:** This policy is subject to a **52 week** eligibility period from 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:**

- Only submit the Claim Form to Bollinger**
- Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
- 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 information contact:** RPS Bollinger, Sports Claims Department  
P.O. Box 390  
Short Hills, NJ 07078-0390  
Phone: 1-866-267-0093  
Email: [SportsClaims@BollingerInsurance.com](mailto:SportsClaims@BollingerInsurance.com)  
Fax: Attn Sports Claims 973-921-2876  
[www.BollingerSoccer.com](http://www.BollingerSoccer.com)

**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.


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## Sports Risk Management Library

The following documents are available for use by Bollinger's clients. Please feel free to download and distribute among your membership.

### Risk Management Reports

- [Are you Fully Protected?](#)
- [Youth Sports Emergency Guidelines](#)
- [Youth Soccer Emergency Plan](#)
- [Field and Facility Inspection Checklists](#)
- [Facility and Field Inspection Guidelines](#)
- [Sports Incident Report](#)
- [Guide to Prevention and Awareness of Abuse](#)
- [Safety 1st \(Market Insurance Company\)](#)
- [Golf Cart Safety](#)

### Soccer Safety Information

- [Bollinger's Soccer Goal Safety Report](#)
- [ASTM Guide to Safer Use of Movable Goals](#)
- [CPSC Guidelines for Movable Goal Safety](#)
- [Chaperones and Team Travel](#)
- [Heat-Related Injuries ~ Prevention and Treatment](#)
- [Sunscreen - The Missing Piece of Protective Equipment](#)
- [Swine Flu Medical Alert](#)
- **Concussion Awareness**
  - [Heads Up - Concussions in Youth Sports](#)
  - [Injury Prevention & Control: Traumatic Brain Injury](#)

### Bollinger Soccer Workshop Presentations

- [Directors & Officers Liability Insurance Overview](#)
- [\\$5mm in Liability Claims and How They Could Have Been Avoided](#)

**Links:** This list represents a sampling of organizations dedicated to promoting youth sports and protecting youth athletes. Bollinger has compiled this list for the benefit of our clients and does not receive any type of remuneration from these organizations.

- US Youth Soccer Association: [www.USYouthSoccer.org](http://www.USYouthSoccer.org)
- National Center for Safety Initiatives (including Criminal Background checks): [www.SafetyInitiatives.org](http://www.SafetyInitiatives.org)
- Positive Coaching Alliance: [www.PositiveCoach.org](http://www.PositiveCoach.org)
- Center for Sports Parenting: [www.SportsParenting.org](http://www.SportsParenting.org)
- National Association of Athletic Trainers: [www.NATA.org](http://www.NATA.org) (go directly to section on issues for Youth Sports at [www.NATA.org/youthsports/index.htm](http://www.NATA.org/youthsports/index.htm))
- Consumer Products Safety Commission – Sports & Recreation Safety, including Soccer Goal Safety: [www.CPSC.gov/cpsc/pub/pubs/rec\\_sfy.html](http://www.CPSC.gov/cpsc/pub/pubs/rec_sfy.html)
- ACL/Knee Injury Prevention Program (presented by the Santa Monica Orthopedic and Sports Medicine Group): [www.ACLPrevent.com](http://www.ACLPrevent.com)



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# Ohio Department of Health Concussion Information Sheet

## For Youth Sports Organizations

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

### What is a Concussion?

A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

### Signs and Symptoms of a Concussion

Athletes do not have to be "knocked out" to have a concussion. In fact, less than 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away or up to 48 hours after the injury. Ignoring any signs or symptoms of a concussion puts your child's health at risk!

#### Signs Observed by Parents of Guardians

- ◆ *Appears dazed or stunned.*
- ◆ *Is confused about assignment or position.*
- ◆ *Forgets plays.*
- ◆ *Is unsure of game, score or opponent.*
- ◆ *Moves clumsily.*
- ◆ *Answers questions slowly.*
- ◆ *Loses consciousness (even briefly).*
- ◆ *Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).*
- ◆ *Can't recall events before or after hit or fall.*

#### Symptoms Reported by Athlete

- ◆ *Any headache or "pressure" in head. (How badly it hurts does not matter.)*
- ◆ *Nausea or vomiting.*
- ◆ *Balance problems or dizziness.*
- ◆ *Double or blurry vision.*
- ◆ *Sensitivity to light and/or noise*
- ◆ *Feeling sluggish, hazy, foggy or groggy.*
- ◆ *Concentration or memory problems.*
- ◆ *Confusion.*
- ◆ *Does not "feel right."*
- ◆ *Trouble falling asleep.*
- ◆ *Sleeping more or less than usual.*

### Be Honest

Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season... or risk permanent damage!

### Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- ◆ *No athlete should return to activity on the same day he/she gets a concussion.*
- ◆ *Athletes should **NEVER** return to practices/games if they still have ANY symptoms.*
- ◆ *Parents and coaches should never pressure any athlete to return to play.*

### The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified health care professional.

### Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete's injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children's brains take several weeks to heal following a concussion.



[www.healthvohioprogram.org/concussion](http://www.healthvohioprogram.org/concussion)

## Returning to Daily Activities

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

## Returning to School

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
  - a. Increased problems paying attention.
  - b. Increased problems remembering or learning new information.
  - c. Longer time needed to complete tasks or assignments.
  - d. Greater irritability and decreased ability to cope with stress.
  - e. Symptoms worsen (headache, tiredness) when doing schoolwork.
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.

### Resources

**ODH Violence and Injury Prevention Program**  
[www.healthyohioprogram.org/vipp/injury.aspx](http://www.healthyohioprogram.org/vipp/injury.aspx)

**Centers for Disease Control and Prevention**  
[www.cdc.gov/Concussion](http://www.cdc.gov/Concussion)

**National Federation of State High School Associations**  
[www.nfhs.org](http://www.nfhs.org)

**Brain Injury Association of America**  
[www.biausa.org/](http://www.biausa.org/)

## Returning to Play

1. Returning to play is specific for each person, depending on the sport. Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can return to play. Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child's coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
4. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified healthcare professional.
5. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child's full recovery would take about one week once they have no symptoms at rest and with moderate exercise.\*

### Sample Activity Progression\*

**Step 1:** *Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).*

**Step 2:** *Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).*

**Step 3:** *Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).*

**Step 4:** *Full contact in controlled practice or scrimmage.*

**Step 5:** *Full contact in game play.*

**\*If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.**



**Ohio Department of Health**  
Violence and Injury Prevention Program  
246 North High Street, 8th Floor  
Columbus, OH 43215  
(614) 466-2144

[www.healthyohioprogram.org/concussion](http://www.healthyohioprogram.org/concussion)



*The Game for All Kids!*

### **Possible Concussion Notification For OYSAN Soccer Events**

Today, \_\_\_\_\_, 2\_\_\_\_, at the \_\_\_\_\_ [insert name of event], \_\_\_\_\_ [insert player's name] received a possible concussion during practice or competition. US Youth Soccer and Staff want to make you aware of this possibility and signs and symptoms that may arise which may require further evaluation and/or treatment.

It is common for a concussed child or young adult to have one or many concussion symptoms. There are four types of symptoms: physical, cognitive, emotional, and sleep.

If your daughter or son starts to show signs of these symptoms, or there any other symptoms you notice about the behavior or conduct of your son or daughter, you should seek immediate medical attention:

- |                                  |                            |                                       |
|----------------------------------|----------------------------|---------------------------------------|
| - Memory difficulties            | - Neck pain                | - Delicate to light or noise          |
| - Headaches that worsen          | - Odd behavior             | - Repeats the same answer or question |
| - Vomiting                       | - Fatigued                 | - Slow reactions                      |
| - Focus issues                   | - Irregular sleep Patterns | - Irritability                        |
| - Seizures                       | - Slurred speech           | - Less responsive than usual          |
| - Weakness/numbness in arms/legs |                            |                                       |

Please take the necessary precautions and seek a physician or licensed healthcare provider before allowing your daughter or son to participate further. Until a medical professional is seen, please consider the following guidelines:

- refraining from participation in any activities the day of, and the day after, the occurrence.
- refraining from taking any medicine unless (1) current medicine, prescribed or authorized, is permitted to be continued to be taken, and (2) any other medicine is prescribed by a licensed health care professional.
- refraining from cognitive activities requiring concentration cognitive activities such as TV, video games, computer work, and text messaging if they are causing symptoms.

Please be advised that a player who has been suspected of a concussion **may not return to play** until they are **provided a written clearance** that it is safe for the individual to return to practice or competition from a *licensed physician or a licensed healthcare provider*. A non-licensed healthcare provider would have to work:

- (a) In consultation with the physician
- (b) pursuant to the referral of a physician
- (c) in collaboration with a physician
- (d) under the supervision of a physician.

Player's Team: \_\_\_\_\_

Age Group: \_\_\_\_\_

Player Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Player Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Team Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Legal Guardian:** *By inserting my name and date, I confirm that I have been provided with, and acknowledge that, I have read the information contained in the Form.*

**Coaches/Officials:** Retain this signed copy for your records. If the parent/legal guardian requests a copy, please fill out in duplicate or photocopy the original for them.

**References:**

Kissick MD, James and Karen M. Johnston MD, PhD. "Return to Play After Concussion." Collegiate Sports Medical Foundation. Volume 15, Number 6, November 2005. [http://www.csmfoundation.org/Kissick\\_-\\_return\\_to\\_play\\_after\\_concussion\\_-\\_CJSM\\_2005.pdf](http://www.csmfoundation.org/Kissick_-_return_to_play_after_concussion_-_CJSM_2005.pdf). April 22, 2011.

National Federation of State High School Associations. "Suggested Guidelines for Management of Concussion in Sports". 2008 NFHS Sports Medicine Handbook (Third Edition). 2008 77-82. <http://www.nfhs.org>. April 21, 2011.

Children's National Medical Center. "Safe Concussion Outcome, Recovery & Education (SCORE) Program." Adapted by Gerard Gioia, PhD; Micky Collins, PhD; Shireen Atabaki, MD, MPH; Noel Zuckerbraun, MD, MPH. <http://www.childrensnational.org/score>. June 27, 2011.





## Return-to-Play Verification

Verification that it is safe for \_\_\_\_\_ to return to practice or competition.

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, the undersigned licensed physician or licensed healthcare provider acting in accordance with O.R.C. § 3707.511(E)(b)(2) may safely return to practice and/or competition for the concussion or possible concussion that occurred on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Physician/Licensed Healthcare Provider

**Rocky River Soccer Organization (RRSO)**  
**Incident Report**

This form is to be used by RRSO coaches or managers when an incident arises that needs to be reported to the RRSO Board of Directors. Such incidents may include player injuries, altercations between players, coaches, referees or parents. This may also include claims of sexual abuse, molestation, exploitation, physical abuse or other crimes that may compromise the safety and well being of participants in the RRSO soccer program. This incident report should be completed as soon as possible after the incident and given to the RRSO President. Please e-mail to President Mike Moore at [president@rrso.org](mailto:president@rrso.org). or call him at (440) 915-6167

Name of Person (s): 1.  2.
Sex: _____ Age or Date of Birth _____
Address of person (s) involved: 1.  2.
Parent's Name (s) 1.  2. Address and Phone: 1.  2.
Date and Time of Incident:
Place Where Incident Occurred:
Description of Person Involved (i.e. coach, player, parent):
Describe How the Incident Occurred (give all possible details):
Describe Any Injuries That Resulted from the Incident:
Name of Event or Activity:
Name (s) and Phone Number (s) of Any Witnesses:

Name (Printed and Signed ) and Date of Person Filing Incident Report:	
Name:	
Signature:	Date:

If possible and appropriate, take pictures at the scene of the incident.

**For RRSO Use Only:**

**Incident Report Submitted to RRSO Official:**

Submitted By:	Submitted To:	Date Submitted:
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**Follow Up Contacts on the Incident Made by RRSO Official:**

Contacts Made By:	Contacts Made To:	Result of Contact:	Date of Contact:
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**Disposition of Incident or Claim:**

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