CAL SOUTH YOUTH SOCCER

Registered Soccer Accident Insurance Claim Form Group Name:
California State Soccer Association – South
Policy # SRG 0009137627-A Effective 07/1/2017 – 6/30/2018

SECTION A – GENERAL INFORMATION (MUST BE COMPLETED IN FULL)

NAME OF PERSON COMPLETING FORM FOR MINORS: (Print Name Below) **You are the (Check one):** Parent • Guardian •

INJURED PERSON NAME : **Last, First, M.I.** **DOB** / / **Male • Female •** **SSN/VISA/GREEN CARD** / /

ADDRESS (Street Address, PO Box, City, State, Zip Code)

EMAIL ADDRESS/ PHONE NUMBER

NATURE OF INJURY (Describe How Injury Occurred and Body Part Injured)

DESCRIBE **WHERE** ACCIDENT OCCURRED: **Practice • Game • Tournament • Camp/Clinic •**
Field Name/Loc: _____ **"Friendly" •**

DATE of INJURY: / /

Tournament Name/Loc: _____

At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes • No •

Name of Supervisor of Activity:

Was he/she a witness to the injury? Yes • No •

SECTION B – PRIMARY INSURANCE (MUST BE COMPLETED IN FULL AND SIGNED BY ALL PARTIES)

Is the Injured Person covered under any other health and/or accident insurance plans? **Yes • No •** If **YES,** give all of the following information:
Name of Other Insurance Company: **Address:** **Policy #:** **Name of Policyholder:**

Employer Name **(Street)** **(City)** **(State)** **(Zip)**

Area Code/Employer Telephone No. ( )

Name of Father or Male Guardian: **SSN/VISA/GREEEN CARD #:**
Place of Employment: **Address of Employer (If Different than above):**
Phone # of Employer: ( )

Name of Mother or Female Guardian: **SSN/VISA/GREEEN CARD #:**
Place of Employment: **Address of Employer (If Different than above):**
Phone # of Employer: ( )

SECTION C – AFFILIATE MEMBER VERIFICATION (TO BE COMPLETED BY CAL SOUTH CLUB/LEAGUE COACH & PRESIDENT)

AFFILIATE MEMBER ID (3 digits) **#:** _____ **PLAYER ID#:** **PLAY TYPE: Competitive • Camp/Clinic • Recreational/Signature •**

AFFILIATE CLUB/LEAGUE NAME:

We do hereby authorize that the claimant is a properly registered player with Cal South and that the injury was sustained during a Cal South sanctioned event.

Cal South Coach of Injured Claimant Signature & Date:	**Cal South Affiliate Member President Signature & Date:**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

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.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. **I authorize payment of medical benefits to the physician or supplier for service performed.** ☐ **YES** ☐ **NO**

X Signature of Claimant or Authorized Representative of Claimant	**Date**

Remit Completed Form To: AIG Accident & Health Claims Dept. P.O. Box 25987 Shawnee Mission, KS 66225-5987
Phone: (800) 551-0824 Fax: (866) 893-8574 Email:A&Hclaimssubmissions@aig.com