

Frequently Asked Questions on Filing an
ASA Team Insurance/Individual Registration Accident Claim

What does the ASA Accident policy cover?

This policy provides coverage for medical expenses that you incur as a result of your participation in supervised ASA Team activities. The policy provides up to \$250,000 in Accident Medical Expense protection, subject to a deductible and 90/10% coinsurance. Treatment and medical expenses are covered for 52 weeks from the date of injury. This is a supplemental policy purchased by the ASA for the benefit of its members to help minimize your out of pocket expenses if you are injured playing softball. The coverage is subject to the limits, conditions and exclusions of the policy and is not designed to cover "everything."

Are there guidelines under the policy for getting treatment and submitting a claim form?

For claims to be eligible for coverage, you must seek medical treatment within 60 days from the date of injury. The ASA claim form must be submitted to Bollinger within 90 days or up to one year from the date of injury.

What happens if I have my own primary medical insurance?

Accident medical expenses are covered under the ASA Accident policy on an Excess Basis, meaning that benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Once you have submitted the claim to your primary insurance plan, you can submit any remaining balances or out of pocket expenses to the ASA Accident plan. Send your itemized bills and EOB's (explanation of benefits) from your primary carrier with a completed Bollinger/ASA claim form to Bollinger to have your claim processed. **Please note:** *It is very important that you follow your primary insurance carrier's eligibility criteria (e.g., to be treated in-network, if required by HMO, etc) in order for your claim to be eligible for coverage under the ASA Accident plan.*

What happens if I have no other insurance?

If you have no other insurance, ASA insurance coverage is primary subject to the deductible, coinsurance and other policy limitations. Send the itemized bills from your doctors or hospitals along with a completed Bollinger/ASA claim form to Bollinger to have your claim processed.

Is there a deductible or coinsurance on the ASA Accident plan?

Depending on the plan selected, JO players and their coaches may have a \$125 or \$250 deductible. Adult players have a \$500 deductible. The deductible applies regardless of whether you have other insurance or not. Please check your membership ID card for details. In addition, the policy has a 90/10% coinsurance clause. This means that after you meet the deductible (if any) for medical services, the ASA Accident insurance pays 90% and you are responsible for the remaining 10%.

How can I make sure that my claim gets paid as quickly as possible?

The most important thing you can do is to fill out the claim form completely and have it signed by a league official and your ASA State Commissioner. Incomplete claim forms are the most common reason for delays in the claims process. Another way to avoid delay is to provide Bollinger with itemized bills (a "CMS-1500" is the standard form used by doctors and dentists, "UB-04" or "UB-92" are the standard form used by hospitals). And if you have primary insurance, you will need to include the explanation of benefits form (EOB) from your primary health insurance carrier.

Questions on your claim?

Please contact Bollinger's Sports Claims Department directly at 866-267-0093 or SportsClaims@BollingerInsurance.com.

Or contact Bollinger's ASA Department at:

Phone ~ 800-526-1379

Fax ~ 973-921-2876

Email ~ ASAInfo@BollingerInsurance.com

HOW TO FILE A CLAIM: INSTRUCTIONS

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

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. 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.

Benefit Period: This policy is subject to a **52 week** benefit 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:**
 - a) **Only submit the Claim Form to Bollinger**
 - b) Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to 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 information contact:

Bollinger, Inc.
Sports Claims Department
P.O. Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-2876
Email: SportsClaims@Bollinger.com

www.Bollinger.com

www.BollingerASA.com



COMPLETE AND RETURN THIS FORM TO:

Medical/Dental Accident
CLAIM FORM



P.O. Box 390 Short Hills, NJ 07078

INDIVIDUAL REGISTRATION

90/10 co-insurance

52 week benefit period

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

- 1. NAME: (first) _____ (last) _____
- 2. ADDRESS: _____ (city) _____ (state) _____ (zip code) _____
- 3. TELEPHONE #: _____
- 4. BIRTHDATE: ___ / ___ / ___ SEX: Male Female SS#: _____
- 5. CLAIMANT IS A: YOUTH COACH/MANAGER OTHER: _____
- 6. NAME OF LEAGUE AND NAME OF TEAM: _____
- 7. TOURN NAME: _____ TYPE: _____ DIRECTOR NAME & #: _____
- 8. ASA ID CARD #: _____ (Include copy of card) FASTPITCH SLOWPITCH
- 9. ACCIDENT DATE: ___ / ___ / ___ ACCIDENT TIME: _____ am pm
- 10. BODY PART INJURED: _____
- 11. ACCIDENT OCCURRED DURING: Game Practice Tournament Camp/Clinic Other _____
- 12. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: _____
- 13. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: _____

SECTION II VERIFICATION TEAM/LEAGUE OFFICIAL SIGNATURE (Required) Policy #: 4102AH220317

I CERTIFY THAT THE ABOVE NAMED CLAIMANT IS AN INSURED MEMBER OF THE TEAM NAMED ABOVE AND THAT THE INJURY OCCURRED DURING OFFICIAL TEAM ACTIVITIES AS STATED.

NAME OF TEAM/LEAGUE OFFICIAL: _____ TITLE: _____

SIGNATURE OF TEAM/LEAGUE OFFICIAL: _____ DATE: _____ PHONE: _____

SECTION III VERIFICATION ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner Signature (Required)

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS A REGISTERED MEMBER OF THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF ASA STATE OR METRO COMMISSIONER: _____ TITLE: _____

SIGNATURE OF ASA STATE OR METRO COMMISSIONER: _____ DATE: _____ PHONE: _____

Check deductible option selected for player/clmt at the time of registration: \$125 _____ \$250 _____ \$500 _____

Was this injury a result of an ASA event? [] yes [] no
If no, indicate name of Organization that held event: _____

SECTION IV**STATEMENT OF OTHER INSURANCE****(Required)****Father/Claimant**

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

EMPLOYER: _____

PHONE: _____

EMAIL: _____

SELF EMPLOYED UNEMPLOYED **Mother/Claimant**

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

EMPLOYER: _____

PHONE: _____

EMAIL: _____

SELF EMPLOYED UNEMPLOYED **If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.**IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NOIS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES NO

INSURED 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**

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

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

1. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or who makes a claim to receive benefits from this policy under false pretense; or conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act, which is a crime, and shall also be subject to a substantial civil penalty to the extent allowed by state law.

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

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

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

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