YOUTH SOCCER ACCIDENT PROOF OF LOSS

SEE REVERSE FOR INSTRUCTIONS

NEW JERSEY YOUTH SOCCER

TO BE COMPLETED BY CLAIMANT

NAME OF CLAIMANT (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐ Male ☐ Female
ADDRESS OF CLAIMANT (Street) (City) (State) (Zip code)	TELEPHONE NUMBER ( )	OCCUPATION	
DATE & TIME OF ACCIDENT		ACCIDENT DUE TO EMPLOYMENT? ☐ Yes ☐ No	
NATURE OF INJURY			

FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT

B. PLACE OF ACCIDENT (BE SPECIFIC)

C. DESCRIBE HOW ACCIDENT HAPPENED

MEDICAL AUTHORIZATION

I hereby authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disability.

Please Sign Here: _____ _____

Claimant (if Adult) or Parent /Guardian Date

PAYMENT AUTHORIZATION

I hereby authorize payment of benefits directly to the providers rendering services.

Please sign here: _____ _____

Claimant (if Adult) or Parent/Guardian Date

STATEMENT OF OTHER INSURANCE

1. Name and Address of Claimant's Employer: (If a minor, complete # 2 & 3)

2. Father's Name or Guardian:	Occupation:	Name and Address of His Employer:	Phone #:
3. Mother's Name or Guardian:	Occupation:	Name and Address of Her Employer:	Phone #:

4. Do you have a Group, Personal Healthcare or Medical plan? ☐ Yes ☐ No

Name of your Health Care Provider	Address

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature _____ Date _____

Claimant (if Adult) or Parent/Guardian