

EFFECTIVE DATE OF COVERAGE September 1, 2003	COVERAGE TERMINATION DATE, IF APPLICABLE September 1, 2004	POLICY NUMBER PST2461Y	NAME OF GROUP POLICYHOLDER New Jersey State Yth Soccer Association
ADDRESS OF POLICYHOLDER (Street) 569 Abbington Dr, Suite C	(City) East Windsor	(State) New Jersey	(Zip Code) TELEPHONE NUMBER 08520 (609) 490-0725
IF ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SUPERVISED BY YOUR ORGANIZATION, DESCRIBE ACTIVITY, HOW ACCIDENT OCCURRED, AND SPECIFY DATE OF OCCURRENCE.			
REMARKS:			

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.	TITLE	DATE
AUTHORIZED SIGNATURE:		

**INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM:**

1. **IMMEDIATELY** submit a claim for all medical expenses to the Company that administers your own personal or group insurance or healthcare plan (including Major Medical coverage). If you have coverage through an HMO or similar facility, you **must** use that facility first or the claim will not be covered under this policy.
2. After your other insurance or healthcare plan has paid the medical expenses up to the policy limits, attach any unpaid bills and copies of payments made by your insurance company (Explanation of Benefits) to this claim form and mail to the address shown below.
3. Please check and make sure that:
  - a) An Official or Administrator of the Policyholder has completed his/her section of the claim form.
  - b) You have completed and signed the Parent/Guardian or Insured's Statement of other Insurance.
  - c) The Medical Records Authorization **MUST** be signed and dated. If you want payments to be sent directly to your doctor or healthcare provider, sign the Payment Authorization Section.
  - d) You have attached all unpaid bills to this form.
  - e) You have attached any Explanation of Benefits forms that you have received from your Primary insurance carrier or other healthcare plan.
  - f) You have completed the front of this form.
4. Subsequent bills should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new claim form is not necessary.**

If you need further information, call Bollinger, Inc. at 800-526-1379. Our Accident Claims fax number is 973-921-2876.

**MAIL THIS FORM AND ALL ITEMIZED BILLS TO:**

New Jersey State Youth Soccer Association  
 Jeanine Willis  
 569 Abbington Dr, Ste C  
 East Windsor, NJ 08520

**PLAN ADMINISTRATOR:**

Bollinger, Inc.  
 P.O. BOX 390, SHORT HILLS, NJ 07078-0857  
 TELEPHONE (800) 526-1379