

Signature of State Verification Officer:

Date:

**CLAIM PROCEDURE: U.S.A.S.A. SPECIAL RISK ACCIDENT CLAIM FORM** Please print or type.

- Participant (or legal guardian if under the age of 18) must complete this form in its entirety or it may be returned to you by the USASA State Association.
- Do not delay submitting this claim form. This form must be received, with or without attachments, within 90 days from the date of the accident or benefits may be denied due to untimely filing.
- Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your U.S.A.S.A. State Association office for validating.
- Once the USASA State Association has validated your claim they will forward it to the insurance company for processing. The insurance company will inform you of any additional information they may need to process your claim.

**1. COMPLETE THIS FORM.**  
**2. ATTACH ALL BILLS.**  
**3. MAIL TO:**  
**Connecticut State Soccer Association**  
**Farmington Sports Arena**  
**11 Executive Drive**  
**Farmington, CT 06032**



<b>Part A</b> – This section MUST be completed by the Injured Person – or by his/her guardian if the Injured Person is under 18 or otherwise dependent.	
1. Name of the Injured Person (Insured): First Middle Last	1a. Date of the Accident: MM/DD/YYYY
2. Complete Mailing Address: Street/City/State/Zip	
3. Area Code /Home Phone	3a. Area Code /Work Phone
4. Social Security Number:	5. Date of Birth : MM/DD/YYYY
6. <input type="checkbox"/> Male <input type="checkbox"/> Female	6a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Full Time Student
7. Are you currently enrolled in any health insurance and/or soccer accident plan?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, all bills must be submitted to them first for consideration. If no see lines 7a and 7b.	
Company Name: _____ Group Name: _____ Policy Number: _____ Company Name: _____ Group Name: _____ Policy Number: _____	
7a. If you are not enrolled in any health insurance plan, we require written verification from your employer and/or your spouse's employer (if applicable), or Bursar's office if you are a full time student.	
7b. If you are self-employed or unemployed and not covered by any health insurance plan ple sign below: Signature of Player: _____	
<b>Part B</b> – This section must be completed, then signed by an official of your local organization.	
1. Team Name:	
2. League Name:	
3. Injury occurred at: <input type="checkbox"/> Event <input type="checkbox"/> Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game	
3a. Name of the event:	
3b. Injury occurred on: <input type="checkbox"/> Indoor Field <input type="checkbox"/> Outdoor Field	
4. Describe how accident happened:	
5. Type of Injury:	
6. Name, Phone Number(s) of Coach, Manager, or Referee present at the time of the accident:	
7. Signature of witness:	

## Authorization

I waive any provision of law to the contrary and hereby authorize The Hartford Life Insurance Company or its representatives to furnish to any hospital, physician, or other person who has attended me, and my insurance carrier, any and all information, with respect to the accidental injury for which I am claiming Insurance benefits.

I waive any provision of the law to the contrary and hereby authorize any hospital, physician, or other person who has attended me, and my insurance carrier, any and all, information with respect to my sickness or injury, medical history, consultation, prescription, or treatments, and copies of all hospital, medical or insurance records including, but not limited to, information, regarding other insurance coverages. I agree that a photocopy of this authorization shall be considered as effective as the original.

(The above paragraphs are being used in order to facilitate our obtaining and providing proper information needed to quickly process your claim.)

---

Signature of Player:

Date: