Participant Claim Form
2022-2023 Player Development Season

Instructions for Reporting an Injury

1. Injured participant or parents of injured participant (if a minor) will complete the Player Development INCIDENT REPORT.

2. Once this INCIDENT REPORT is complete email the report to the Fairly Group at daclaims@fairlygroup.com and PlayerDevelopmentClaims@mlsplayerdevelopment.com. The INCIDENT REPORT should be sent to the Fairly Group as soon as possible after the injury but must be within 72 hours of the injury.

   ***** No bills can be processed by the Player Development Policy, administered by Health Specialty Risk (HSR) until a completed incident report has been sent to Player Development.**

3. This Player Development policy is a secondary/excess accident medical policy and is designed as a supplement to any other insurance coverage you have. You **must** file a claim with your family health insurance prior to filing anything under this policy. Please be sure to supply your medical provider your other insurance information as primary coverage and the Claims Submission From with the information for this policy as secondary. If you provide the above information to the medical providers who treat you for your injury, this will give allow them to bill the appropriate insurance on the nationally required forms. If you do not have any other insurance, you must supply the Medical Approval Form to any medical providers. If you do not provide this information the medical provider will not be able to bill insurance and will most likely request payment from you directly.

4. **Important ** If you do not have any other insurance and your medical treatment is not an emergency please note that the following treatments require approval prior to service: Surgeries, MRI's, CT Scans, Durable Medical Equipment and Physical Therapy. If you are having any of the above treatment you will need to make sure that your medical provider receives the attached Medical Approval Form prior to services.**

5. Treatment must commence within 90 days from the date of the injury to be eligible for benefits under the Player Development policy. This policy h a s a 52-week benefit period from the date of injury. This means only charges incurred within 52 weeks from the date of injury will be covered under this policy. Any charges incurred after the 52-week benefit period will not be covered.

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1. PLEASE FULLY COMPLETE THIS FORM
2. EMAIL THIS FORM TO: daclaims@fairlygroup.com & playerdevelopmentclaims@mlsplayerdevelopment.com

PLAYER DEVELOPMENT

PARTICIPANT CLAIM FORM

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE PROVIDED AND LEGIBLE. **OMISSION OF INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.**

(PRINT/TYPE REQUIRED)

INJURED PERSON INFORMATION:

Last Name_____First Name_____MI ____

Employer_____Spouse's Name _____

(If Minor)
Father's Name:_____Mother's Name_____

Address_____Email _____

City_____State_____Zip_____Phone (_____) _____

Social Security Number_____Date of Birth_____Current Age_____ ☐ Male ☐ Female

Are you a (choose one): ☐ ATHLETE ☐ COACH ☐ OFFICIAL ☐ OTHER _____

FAMILY HEALTH INSURANCE:

(Health Insurance MUST be filed prior to this policy)

Insurance Company: _____

Policy holder's name: _____

Policy Number: _____

Group Number: _____

TIME, PLACE AND DETAILS OF INCIDENT:

Date of Incident_____Time of Incident_____AM PM

Body Part Injured: ☐ R ☐ L _____

Type of injury (choose one): ☐ Laceration ☐ Sprain/Strain ☐ Fracture ☐ Contusion ☐ Concussion ☐ Dental

☐ Other: _____

Severity (choose one): ☐ Report only ☐ Minor ☐ Serious ☐ Critical ☐ Fatality

Did you receive onsite care? ☐ **Y** ☐ **N** Were you taken by ambulance to a hospital? ☐ **Y** ☐ **N**

What event were you participating in at the time of the incident? _____

Was there a certified Coach at this event? ☐ **Y** ☐ **N** If so include name _____

What was the location of the event? _____

Describe what happened: _____

_____

Was there a witness to the incident? ☐ **Y** ☐ **N**

WITNESSES:

(If there was a witness please complete this section)

Witness name: _____ Witness name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE HSR, THE FAIRLY GROUP, OR THEIR 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 LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH HSR, THE FAIRLY GROUP, OR THEIR REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, 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.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

I FURTHERMORE AUTHORIZE MEDICAL PAYMENTS TO BE MADE DIRECTLY TO ANY PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED ON ANY STATEMENTS RECEIVED BY HSR RELATING TO THIS INCIDENT.

BY MY SIGNATURE BELOW I CERTIFY THAT THIS INJURY OCCURRED TO A PLAYER-DEVELOPMENT REGISTERED MEMBER DURING A PLAYER-DEVELOPMENT SANCTIONED EVENT AND THAT I HAVE LISTED ANY EXISTING HEALTH INSURANCE COVERAGE ABOVE. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHERMORE UNDERSTAND THAT OMMISSION OF REQUESTED INFORMATION OR FRAUDULENT STATEMENTS CAN BE A CRIME.

Claimant Signature _____ **Date** _____

This section to be completed and signed by CLUB REPRESENTATIVE (e.g. Coach, Admin Staff):

CLUB OF INJURED: _____

LOCATION OF INCIDENT (CITY, STATE) _____

I ATTEST THAT THE ABOVE-REFERENCED INCIDENT OCCURED ON THIS DATE _____ WHILE _____ (print athlete name) WAS PARTICIPATING IN A PLAYER DEVELOPMENT SANCTIONED EVENT.

ATHLETE, COACH or OFFICIAL (print) _____ Title _____

SIGNATURE OF COACH, ATHLETE, OFFICIAL: _____ Date _____

INSURED REPRESENTATIVE NAME: Fairly Group Representative.

SIGNATURE _____ Date _____

By entering your name above, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.