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## EASTERN NEW YORK YOUTH SOCCER ASSOCIATION

53 NORTH PARK AVE. SUITE 103, ROCKVILLE CENTRE, NY 11570  
PHONE: 516-766-0849 - FAX: 516-678-7411 - EMAIL: ENYOFFICE@ENYSOCCER.COM  
WWW.ENYSOCCER.COM

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### **Advance Notice of Injury/Claim Form Procedure**

When reporting an injury the following procedure is taken:

1. The Advance Notice of Injury form must be completed by the Coach and submitted to your League.

**Note:** You have 90 days from date of injury to submit the claim form. For claims to be eligible for coverage you must seek medical attention within 60 days from the date of injury.

2. The League then verifies that the player is registered and that the injury occurred at a sanctioned ENYSSA event. Once verified, the League approves and forwards to the ENYSSA State Office.
3. ENYSSA receives the Advance Notice of Injury form from the League, reviews and approves. The Claim Form is forwarded to the parent / guardian via e-mail. It is important that you include a current e-mail address on the form.
4. The parent / guardian must complete the Claim Form and return to the ENYSSA State Office for processing. **If the Claim Form is not returned a claim will not be filed with the Insurance carrier.**
5. ENYSSA forwards the Claim Form to the Insurance carrier.
6. At this point, inquiries should be directed toward the insurance carrier at (866) 738-6100
7. When submitting bills to our insurance carrier, please ensure the following:
  - Each itemized bill MUST show the following:

- Provider of Service's Name
  - Provider's Address
  - Provider's Federal Tax ID#
  - Provider's Telephone #
  - Date of Service
  - Diagnosis Description or Codes (ICD-9)
  - Procedure Description or Codes (CPT)
  - Charge for each Procedure
- Additional bills to be submitted at a later date (after the initial submission of your claim) should be mailed directly to K&K Insurance with the following information: Name of the claimant, date of the accident, and name of the State Youth Soccer Association.
  - Please respond promptly to any correspondence requesting additional information. It is the Parent / Guardian / Claimant's responsibility to request this information from the provider of service or from your primary carrier.
  - An Explanation of Benefits will be sent to you by K&K Insurance on behalf of National Union Fire Insurance Company.

**Note:** There is a **\$500 deductible** per covered accident per policy year. Each claim is also subject to the application of a \$50 physical therapy/chiropractic limit per visit/\$2,000 total maximum.



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## **ADVANCE NOTICE OF INJURY**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

CLUB: \_\_\_\_\_ TEAM: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ TIME: \_\_\_\_\_ PLACE: \_\_\_\_\_

EVENT: \_\_\_\_\_ (who was opponent)

TYPE OF INJURY: \_\_\_\_\_

HOW DID INJURY OCCUR? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DOES THE INJURED PLAYER HAVE PRIMARY INSURANCE? \_\_\_\_\_ YES \_\_\_\_\_ NO

COACH: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SIGNATURE OF COACH: \_\_\_\_\_ DATE: \_\_\_\_\_

AFTER COMPLETING THE ABOVE, PLEASE SEND THIS FORM TO YOUR LEAGUE OFFICE.

LEAGUE APPROVAL \_\_\_\_\_ DATE: \_\_\_\_\_