SPORTS INSURANCE SPECIALISTS

YOUTH SPORTS / SPECIAL RISK

ACCIDENT CLAIM FORM

Please complete and submit to A-G Administrators with itemized medical bills AND primary insurance explanation of benefits.

Send all claim forms and documents using our secure upload portal: upload.agadministrators.com
Alternatively, submit documents to msysa@agadm.com.

For questions, however, please contact A-G Administrators: customerservice@agadm.com.

ORGANIZATION: MICHIGAN STATE YOUTH SOCCER ASSOCIATION CLUB NAME: _____

Team Name: _____ League Name: _____

Participant's Name: _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth: _____ Sex: ☐M ☐F Player ID: _____

Parents Phone: _____

Parents EMAIL: _____

Participant's Home Address: _____
STREET CITY STATE, ZIP

ACCIDENT INFORMATION

Type of Activity: ☐League ☐Tournament ☐ Team Event Accident Date: _____ Body Part Injured: _____

Name of Field/Facility: _____ City of Field/Facility: _____

Nature of Injury (Details of what happened.): _____

_____

_____

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐Yes ☐No (Attach separate documents if necessary.)

Insurance Company Name/Address: _____

Policy Number: _____ ID#: _____

AUTHORIZATION

AFFIDAVIT: I verify the statement regarding other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization, or any family member to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees. I also authorize A-G Administrators to release medical and billing information to any family member or health care provider if necessary to facilitate any potential payments.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

PARENT SIGNATURE	**DATE**
MSYSA AUTHORIZED CLAIM CONTACT	**DATE**

Please complete this form electronically and send via email to msysa@agadm.com

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