Markel Insurance Company

COMMERCIAL GENERAL LIABILITY POLICY DECLARATIONS

Policy No. 3602AH024981 - 5

3602AH024981-4
Renewal of Policy No.

Named Insured and Mailing Address (No., Street, Town or City, County, State, Zip Code)

Connecticut Football Officials Association
c/o Ed Carboni, Jr.
503 Boston Post Road
Waterford, CT 06385

Policy Period: from 08-16-2012 until 08-16-2013, at 12:01 A.M. Standard Time at your mailing address shown above.

IN RETURN FOR THE PAYMENT OF THE PREMIUM AND SUBJECT TO ALL TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

LIMITS OF INSURANCE

General Aggregate Limit (Other Than Products--Completed Operations)	$ 3,000,000	
Products--Completed Operations Aggregate Limit	$ 1,000,000	
Personal and Advertising Injury Limit	$ 1,000,000	
Each Occurrence Limit	$ 1,000,000	
Damage To Premises Rented To You Limit	$ 100,000	Any One Premises
Medical Expense Limit	$ 5,000	Any One Person

RETROACTIVE DATE (CG 00 02 only) N/A IN STATE OF NEW YORK

Coverage A of this Insurance does not apply to 'bodily injury' or 'property damage' which occurs before the Retroactive Date, if any, shown here: None
(Enter Date or "None" if no Retroactive Date applies)

DESCRIPTION OF BUSINESS AND LOCATION OF PREMISES

Form of Business: Association

Business Description: Amateur Sports

Location of All Premises You Own, Rent or Occupy:

88707 / Bollinger Inc
PO Box 390
101 JFK Parkway
Short Hills, NJ 07078

SEE ATTACHED "EXTENSION OF DECLARATIONS"

PREMIUM

Classification	Code No.	Premium Basis	Rate	Advance Premium

SEE ATTACHED "EXTENSION OF DECLARATIONS"

Total Advance Premium: $ 1,417.00

FORMS AND ENDORSEMENTS

Forms and Endorsements applying to this Coverage Part and made part of this policy at time of issue:

MJ1(04/95), MD002(09/99), CG0001(12/07), CG2026(07/04), CG2407(01/96), MGL101(09/95), MGL102(10/09), MGL129(05/09), MGL132(09/95), MGL187(05/09), MGL215(02/03) MIL024(03/00), CG0068(05/09), CG2173(01/08), MGL-TERR-2(01/08), CG2133(11/85), CG2135(10/01), CG2147(12/07), CG2149(09/99), CG2160(09/98), CG2196(03/05), MGL182(06/98) MGL223(07/05), MIL004(03/00), MIL004(03/00), MIL006(05/09), MIL140(10/01), IL0140(09/08), IL0260(02/10), IL0017(11/98), IL0021(09/08)

Countersigned: 06-28-2012
JLU Glen Allen, VA

By Bruce A. Kay Bruce A. Kay

THESE DECLARATIONS TOGETHER WITH THE COMMON POLICY CONDITIONS, COVERAGE PART DECLARATIONS, COVERAGE PART COVERAGE FORM(S) AND FORMS AND ENDORSEMENTS, IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETE THE ABOVE NUMBERED POLICY.

Insured

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. Payment under this policy will be made according to **usual and customary guidelines.** This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **90** days from date of injury to submit claim form.
   For claims to be eligible for coverage, you must seek medical attention within **60 days** from date of injury.
   Benefit Period: This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. Please remember:
   a) Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
   b) Itemized bills are required: You or your providers must submit itemized bills; balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.
      - **HCFA-1500** is the standard form used by Providers, such as doctors and dentists, to show the medical treatments and charges made for each service.
      - **UB-04 or UB-92** is the standard form used by Hospitals to show medical treatments and charges made for services.
      - Primary Insurance **Explanation of Benefits (if applicable).**

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.

5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.

a.) Employer contribution to flex account - Send to Primary insurance first, then flex account, then Bollinger

b.) Employee contribution to flex account - Send to Primary insurance first, then Bollinger, then flex account. If monies have been paid out of your flex account before Bollinger then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

For further Claims information contact:

Bollinger Sports Claims Department
PO Box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-2876
Email: SportsClaims@BollingerInsurance.com

Bollinger
Insurance Solutions

COMPLETE AND RETURN THIS FORM TO:

Bollinger
Insurance Solutions

P.O. Box 390 Short Hills, NJ 07078

Medical/Dental Accident
CLAIM FORM

52-week benefit period

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

1. NAME:(first)_____(last)_____
2. ADDRESS:_____(city)_____(state)_____(zip code)_____
3. TELEPHONE #: _____
4. BIRTHDATE: ___/___/____ SEX: Male☐ Female☐ SS#:_____
5. CLAIMANT IS A: ☐ Player ☐ Coach ☐ Official ☐ Other
6. ACCIDENT DATE: __/__/__ ACCIDENT TIME:_____ ☐ am ☐ pm
7. BODY PART INJURED:_____
8. ACCIDENT OCCURRED DURING: ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Other_____
9. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:_____
10. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURED:_____

SECTION II STATISTICAL INFORMATION (required)

1. NAME OF TEAM/CLUB:_____
2. TYPE: ☐ Competitive ☐ Recreational
3. LOCATION: ☐ On Field ☐ Indoor ☐ Spectator Area ☐ Other
4. SURFACE: ☐ Dirt ☐ Grass ☐ Outdoor Turf ☐ Indoor Turf
5. SURFACE CONDITION: ☐ Dry/Normal ☐ Wet/Rainy ☐ Icy ☐ Muddy
6. POSITION: _____
7. STATUS: ☐ HIT BY OBJECT ☐ COLLISION W/OPPONENT ☐ COLLISION W/TEAMMATE

☐ OTHER_____

SECTION III TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL (required)

Policy Effective Date	Policy Expiration Date	Policy #	Name of Policyholder
08-16-2011	08-16-2012	4102AH024980 - 4	Connecticut Football Officials Associati

ADDRESS OF POLICYHOLDER (Street)	(City)	(State)	TELEPHONE NUMBER
c/o Ed Carboni, Jr.	503 Boston Post Road		

VERIFY THAT ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SANCTIONED BY YOUR ORGANIZATION, AND WHETHER CLAIMANT WAS A MEMBER AT THE TIME OF ACCIDENT.

☐ YES-SPONSORED/SANCTIONED ACTIVITY
☐ YES-CLAIMANT WAS ACTIVE MEMBER ON DATE OF ACCIDENT

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

SECTION IV STATEMENT OF OTHER INSURANCE (required)

Claimant/Father

Name:_____
Address:_____
City:_____
State:_____ Zip Code:_____
Phone:_____
Employer:_____
Phone:_____
Self Employed ☐ Unemployed ☐
Email: _____

Claimant/Mother

Name:_____
Address:_____
City:_____
State:_____ Zip Code:_____
Phone:_____
Employer:_____
Phone:_____
Self Employed ☐ Unemployed ☐
Email:_____

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY?

☐YES ☐NO

IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID?

☐ YES ☐ NO

INSURED NAME: _____ ID#: _____ INSURED GRP#/NAME: _____

INSURANCE COMPANY NAME:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE:_____

**Please include copy of insurance card (both sides)

Note: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: _____

SECTION V ASSIGNMENT OF BENEFITS (required)

For services rendered or to be rendered I hereby authorize the Insurance Company or their representatives to pay benefits in connection with this accident or injury directly to the doctor, hospital or other provider of service. If paid receipts are submitted with this claim form, benefits will be paid to the insured.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required): _____ DATE:_____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger or HSR or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required): _____ DATE:_____