



1712 Magnavox Way P.O. Box 2338
 Fort Wayne, Indiana 46801
 1-800-237-2917 Fax 1-312-381-9077
 www.kandkinsurance.com
 CA #0334819

BABE RUTH LEAGUE, INC. ACCIDENT PROOF OF LOSS CLAIM FORM

on behalf of Nationwide Life Insurance Company

PART II - TO BE COMPLETED BY LEAGUE OFFICIAL

League name: _____ Babe Ruth team name: _____
 League or authorized league official's address: _____
 City: _____ State: _____ Zip: _____

<p>BASEBALL <i>(Please check one)</i></p> <p><input type="checkbox"/> Major Cal Ripken <input type="checkbox"/> Minor Cal Ripken <input type="checkbox"/> 13-15 League <input type="checkbox"/> 13 Prep League <input type="checkbox"/> 16-18 League <input type="checkbox"/> 16 Prep League <input type="checkbox"/> Bambino Buddy Ball</p>	<p>SOFTBALL <i>(Please check one)</i></p> <p><input type="checkbox"/> Major 12 & Under <input type="checkbox"/> Minor 12 & Under <input type="checkbox"/> 14 & Under League <input type="checkbox"/> 16 & Under League <input type="checkbox"/> 18 & Under League</p>	<p>CLAIMANT IS A: <i>(Please check one)</i></p> <p><input type="checkbox"/> Player <input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Non-Player Personnel <input type="checkbox"/> Umpire</p>	<p>ABSENCE FROM PLAY: <i>(Please check one)</i></p> <p><input type="checkbox"/> Pre-Season <input type="checkbox"/> Regular Season <input type="checkbox"/> Tournament <input type="checkbox"/> Travel Ball <input type="checkbox"/> Dual Participation <input type="checkbox"/> World Series</p> <p><input type="checkbox"/> < One Week <input type="checkbox"/> 1-3 Weeks <input type="checkbox"/> 3+ Weeks</p>
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Injured person's full name: _____ Date of birth: _____
 Claimant's social security number: _____ Date/hour of accident: _____ Time: _____ A.M./P.M.
 Place injury occurred: _____

<p>INJURY:</p> <p>Injured body part: _____ Condition: _____ (laceration, concussion, fracture, sprain, etc.)</p>	<p>SIDE:</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> N/A</p>	<p>TIME:</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Lights</p>	<p>DISPOSITION:</p> <p><input type="checkbox"/> On-site care only <input type="checkbox"/> Ambulance to _____ City _____ <input type="checkbox"/> Fatality <input type="checkbox"/> Refused care</p>
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<p>OCCASION:</p> <p><input type="checkbox"/> TO/FROM GAME <input type="checkbox"/> WARMUPS <input type="checkbox"/> DURING GAME (_____ Inning) <input type="checkbox"/> BETWEEN INNINGS <input type="checkbox"/> TO/FROM PRACTICE <input type="checkbox"/> PRACTICE: (Early) (Mid) (Late) <input type="checkbox"/> PRACTICE GAME CONDITIONS <input type="checkbox"/> OTHER: _____</p>	<p>LOCATION:</p> <p><input type="checkbox"/> BASE: (1st) (2nd) (3rd) (HP) <input type="checkbox"/> BASEPATH <input type="checkbox"/> INFIELD <input type="checkbox"/> OUTFIELD <input type="checkbox"/> FOUL TERRITORY <input type="checkbox"/> DUGOUT <input type="checkbox"/> BULL PEN <input type="checkbox"/> LOCKER ROOM <input type="checkbox"/> OTHER: _____</p>	<p>ACTIVITY:</p> <p><input type="checkbox"/> BATTING <input type="checkbox"/> RUNNING <input type="checkbox"/> SLIDING <input type="checkbox"/> CATCHING <input type="checkbox"/> FIELDING <input type="checkbox"/> TAGGING <input type="checkbox"/> THROWING <input type="checkbox"/> PITCHING <input type="checkbox"/> OTHER: _____</p>
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<p>SITUATION:</p> <p><input type="checkbox"/> HIT BY (Pitch) (Bat) (Foul) (Thrown Ball) (Batted Ball) Other _____ <input type="checkbox"/> COLLISION WITH: (Teammate) (Opponent) (Fence) Other _____ <input type="checkbox"/> NON-CONTACT INJURY <input type="checkbox"/> FALL (Slip) (Trip) (Pushed) <input type="checkbox"/> OTHER _____</p>	<p>DESCRIBE HOW ACCIDENT HAPPENED:</p> <p>_____</p>
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League official's name: _____ League official's signature: _____
Please Print
 Title: _____ Daytime phone: _____ Date: _____



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BABE RUTH LEAGUE, INC.
MEDICAL CLAIM FORM

NOTE: CLAIM FORM WILL BE RETURNED IF NOT FULLY COMPLETED
AND SIGNED BY THE AUTHORIZED LEAGUE OFFICIAL.

HOW TO FILE YOUR CLAIM

TO THE PARENT/GUARDIAN:

- 1. Part I is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
2. Attach itemized physician, hospital or other provider's bills for accident medical expenses being claimed.
3. If using this insurance as your secondary insurance, attach Explanation of Benefits statements from the primary carrier.

If you have an appointment with a doctor as the result of an injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

TO THE DOCTOR OR PROVIDER:

This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates:

TO THE LEAGUE:

- 1. Part II must be fully completed and signed by the League Official.
2. Make copies of the claim form after it is completed and signed by the league official and patient or parent/guardian.
3. The authorized league official should mail the completed claim form and make note of date mailed to:

K&K Insurance Group, Inc.
Claims Department
P.O. Box 2338
Fort Wayne, IN 46801



NOTE: There is a \$100.00 per person deductible.
Plan pays for covered medical expenses which occur within 52 weeks from the date of the injury.

PART I - TO BE COMPLETED CLAIMANT - OR PARENT/GUARDIAN IF CLAIMANT IS A MINOR

Plan pays for covered medical expenses which occur within 52 weeks from the date of the injury.
There is a \$100 per person deductible.

PRINT Names of parent or guardian (or claimant if not a minor):

Phone:()

PRINT Address of Parent or Guardian (or claimant if not a minor):

Mailing Address:

City:

State:

Zip:

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize the release of any and all medical information required to process this claim.

A photostat of this authorization shall be considered as effective and valid as the original.

I authorize any licensed physician, health care practitioner, hospital, clinic, medical or medically-related facility, insurance or reinsuring company, insurance support organization, consumer reporting agency, employer, or any other person or organization having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or drug, alcohol or psychiatric treatment and any other non-medical information to give to K&K Insurance Group, Inc., or its legal representative, any and all such information.

Patients or parent/guardian's

Signature: _____

Date: _____

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files a statement or claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.