

2011 ACCIDENT CLAIM FORM

(Dixie Youth, Dixie Boys/Majors, Dixie Softball)

Instructions For Filling Out This Claim Form

(Should be read by League Presidents, Team Officials and Parents)

Our objective is to provide fast and accurate claims service. Listed below are some brief instructions that, when followed, will assist us in providing this service.

WHEN TO FILE A CLAIM:

1. Since this policy contains an EXCESS MEDICAL EXPENSE BENEFIT, YOU MUST FIRST FILE THE CLAIM WITH YOUR EXISTING INSURANCE PLANS (including major medical) before we may determine what payments, if any, we owe. Note: If your family carrier is an HMO or PPO, you must always follow their rules for obtaining benefits.
2. Written proof of loss (the completed claim form and supporting documents) should be given to the Claims Administrator within 90 days after the loss starts.

HOW TO FILE A CLAIM:

1. All questions must be answered in FULL for us to process the claim. Failure to answer even one question, regardless of whether or not you think it is relevant, may result in the claim form being returned and subsequent delay.
2. Part 1 and Part 2 must be completed and certified by the authorized TEAM OFFICIAL (Make sure the LEAGUE name is on the claim form – not the team name.)
3. Part 3 must be completed and certified by the PARENT/GUARDIAN of the claimant or the claimant himself if he is an adult. If there is no existing insurance company, simply state "none" under the appropriate space. If a parent is not employed, simply state "unemployed" under the appropriate space.
4. Submit all bills to your family insurance carrier.
5. Your insurance carrier will send you an Explanation of Benefits (EOB) listing the payments made by them. Upon receipt of the EOB from your insurance carrier, forward the EOB along with all itemized bills and the completed 2011 Accident Claim Form to the Maksin Management Corporation (address below) for processing.
6. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance, or Self Provided): Complete the information on the 2011 Accident Claim Form, sign where indicated, include all your itemized bills and forward to the claims administrator for processing. PLEASE INCLUDE a written statement from the parent's/claimant's employer(s) verifying that no coverage exists.
7. All benefits will be made payable to doctors and hospitals involved unless you provide a "paid" receipt.

TO SUBMIT ADDITIONAL BILLS after the original claim form has been sent in, be sure to include the following: name of claimant, date of accident, name of league, claimant's social security number, and your League's 2011 Accident Insurance Policy Number.

We recommend that you always make a photocopy of the 2011 Accident Claim Form (pages 1-3), all itemized bills, etc. before forwarding to claims administrator.

WHERE TO FILE CLAIM:

1. Send all completed forms, itemized bills, etc. to Maksin Management Corp. at the address shown below.
2. Any questions concerning the status of benefit payments should also be directed to Maksin Management Corp. at the toll free phone number shown below:

Dixie Baseball / Softball Administrator
Maksin Management Corp.
P. O. Box 2648
Camden, NJ 08101-2648
1-800-257-6250

IMPORTANT - PLEASE NOTE:

**DO NOT SEND YOUR CLAIM FORM OR MEDICAL BILLS TO SADLER & COMPANY
AS IT WILL CAUSE A DELAY IN YOUR CLAIM BEING PROCESSED AND PAID**

2011 DIXIE ACCIDENT CLAIM FORM

(CHECK ONE: Youth Boys/Majors Softball)

FOR OFFICE USE ONLY

Claim Number: _____

PART 2 – TO BE COMPLETED IN FULL BY AUTHORIZED TEAM OFFICIAL

(1) Name of Organization (One: Dixie Youth Baseball, Inc. Dixie Boys/Majors, Inc. Dixie Softball, Inc.		(2) Name of League:	
(3) Name of Claimant (injured person): _____ (Last, First, Middle)		(4) Social Security Number:	(5) Birthdate: ____/____/____ mm dd yyyy
(6) Date of Injury: ____/____/____ mm dd yyyy	(7) Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM hh:mm	(8) Place Injury Occurred:	
(9) Nature of Injury (please describe fully indicating what part of body was injured – such as broken arm, sprained ankle, etc.):			
(10) Describe how accident occurred (give all possible details, i.e., hit by pitched ball, sliding into 2 nd , etc.			

(11) Did accident occur: (check <input type="checkbox"/> Yes or <input type="checkbox"/> No): a) While claimant was supervised <input type="checkbox"/> Yes <input type="checkbox"/> No b) During sponsored activity <input type="checkbox"/> Yes <input type="checkbox"/> No c) On activity premises <input type="checkbox"/> Yes <input type="checkbox"/> No d) While traveling to or from a regularly scheduled activity in a supervised group <input type="checkbox"/> Yes <input type="checkbox"/> No	(12) 2011 Reference & Policy Number (CHECK ONE OPTION BELOW) Dixie Youth Baseball: <input type="checkbox"/> Ref #: CHS9936671 / Pol #: SRG9499283 Dixie Boys & Majors: <input type="checkbox"/> Ref #: CHS9936651 / Pol #: SRG9499283 Dixie Softball: <input type="checkbox"/> Ref #: CHS9936661 / Pol #: SRG9499283 (13) Name and Title of Supervisor/Team Official (PLEASE PRINT CLEARLY):
(14) Name of activity or sport:	(15) Injured person is: (check one) <input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Player <input type="checkbox"/> Other: _____

16. The above named claimant is a regular member of the policyholder and was injured while a regular member of such team and in the manner described above	17. Daytime Phone of Team Official: _____ <small>Area Code & Phone Number</small>
18. Signature (Team Official) Listed in #13 Above	19. Title: _____
20. Date: _____	
21. Mailing Address of Team Official Listed in #13 Above: Street: _____ City: _____ State: _____ Zip: _____	

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

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL.

PART 3 – TO BE COMPLETED IN FULL BY PARENT/GUARDIAN (OR BY CLAIMANT IF AN ADULT)

1. Name of Claimant’s Father/Guardian or Claimant (if adult)	1a. Social Security Number:
2. Name of Claimant’s Mother /Guardian or Claimant (if adult)	2a. Social Security Number:
3. Address of Claimant’s Parent/Guardian or Claimant (if adult)	3a. Daytime Telephone Number:
4A Father, Guardian or Claimant’s Insurance Company(ies) Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group	5A Mother, Guardian or Spouse’s Insurance Company(ies) Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group
4A Name & Address of Father, Guardian or Claimant’s Employer (Employer’s Name): _____ (P.O. Box or Street): _____ (City) _____ (State) _____ (Zip) _____ (Daytime Phone): (_____)	5B Name & Address of Mother, Guardian or Spouse’s Employer (Employer’s Name): _____ (P.O. Box or Street): _____ (City) _____ (State) _____ (Zip) _____ (Daytime Phone): (_____)

6. List other insurance policies under which claimant is insured:		
6a: Company Name:	6b: Policy #:	Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group
6c: Company Name:	6d: Policy #:	Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group

Affidavit: I verify that the above statement on 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.

Signature of Parent or Guardian X _____ Date: _____

Authorization: I hereby authorize any physician or hospital that has treated or attended the above claimant to furnish American Fidelity Assurance Company or its representative any information requested. A photocopy of the authorization is to be considered valid. Signature of Parent or Guardian X _____ Date: _____