

2012 ACCIDENT CLAIM FORM

DIZZY DEAN BASEBALL, INC.

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. Please keep in mind that we are not saying your claim will be paid, we are saying if all conditions are met, then this claim will be considered for payment.

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:

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.

There are four basic items that are required in order for a claim to be considered eligible for benefits. All claim forms received are initially enrolled, however, until all required information is received we are unable to review the claim for payment.

1) A COMPLETED CLAIM FORM / PART I {Claim Form} and PART II {Proof of Loss}

Please be sure to neatly and fully complete your CLAIM FORM and PROOF OF LOSS form. If you do not have a Claim Form or Proof Of Loss form, please call (800) 622-7370 for assistance. Your claim form must have a policyholder's authorized signature (#17 on the Claim Form). The policyholder representative is the league administrator who acts on behalf of the policyholder to verify your claim. The policyholder is the sports organization that purchased the coverage for the team or league you were involved with at the time you were accidentally injured. The PROOF OF LOSS form must be signed on item #23 and #24-25.

2) A COMPLETED INJURY REPORT (PART III)

This is a required form, and should be completed by the authorized team or squad official. (Please be sure to answer ALL questions on this form.)

3) COPIES OF FULLY ITEMIZED BILLS

Please contact the providers of medical service directly for an itemized billing. An Itemized bill is usually in the HCFA-1500 or UB-04 format which means the bill should have a date of service, patient name, billing address and phone, provider tax identification number, procedural codes, and diagnosis codes. If your bill does not have this information, please call the provider of service directly and request they mail it to us or call our office for assistance.

4) COPIES OF YOUR FAMILY HEALTH INSURANCE CARRIERS EXPLANATIONS OF BENEFITS

The policy selected by the policyholder is in excess to any other available source of medical benefits. This means that you must file your bills through your primary, or personal insurance carrier prior to this policy. When your insurance company processes the charges, they will send you an Explanation of Medical Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

IF YOU DO NOT HAVE ANY OTHER AVAILABLE INSURANCE COVERAGE, fully complete Section II of the claim form as directed above, indicating "NO" in response to each insurance question, if appropriate. You **MUST** sign the insurance portion of the form if you have no other coverage. Please remember that this is a signed and sworn legal document.

TO SUBMIT ADDITIONAL BILLS after the original claim form has been sent in, be sure to include the following: name of injured person/claimant, date of accident, name of league, claimant's social security number, and your League's 2012 Accident Insurance Policy Number.

We recommend that you always make a photocopy of the 2012 Accident Claim Form (pages 1-3), all itemized bills, etc. before forwarding to claims administrator.

For specific policy information, please call to verify benefits. It is important to remember that policy wording or any verbal verification of benefits does not guarantee payment. Some policies may have specific medical equipment exclusions or specific treatment type limitation, i.e., physical therapy or ambulance. It is important to remember that any statement of policy information does not guarantee the payment of any medical expense. Benefit determination can only be made once the entire claim and supporting documentation has been received and reviewed by the claims examiner.

Every policy has both an effective date (which must be prior to the injury date) as well as a benefit period, which is the period of time for which benefits are available for treatment to that injury. Treatment received past the benefit period is not eligible for benefits.

WHERE TO FILE CLAIM:

1. Send all completed forms, itemized bills, etc. to American Specialty Insurance & Risk Services, Inc., at the address shown below.
2. Any questions concerning the status of benefit payments should also be directed to American Specialty Insurance & Risk Services, Inc., at the toll free phone number shown below:

**Dizzy Dean Baseball - Claims Administrator
American Specialty Insurance & Risk Services, Inc.
P. O. Box 459
Roanoke, IN 46783
Phone: 1-800-566-7941
Fax: 260-673-1189**



**DIZZY DEAN BASEBALL & SOFTBALL
2012 SEASON - ACCIDENT CLAIM FORM**
Underwritten by: ACE American Insurance Company

POLICY NUMBER: PTP-N00720185

Please Type or Print – Use Black Ink

PART I – POLICYHOLDER’S REPORT (Must Be Completed By Authorized Team / League Official)			
Fraud Warning: “It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.”			
1. NAME OF ORGANIZATION THAT PURCHASED COVERAGE:		2. NAME OF TEAM:	
3. MAILING ADDRESS OF ORGANIZATION THAT PURCHASED COVERAGE:			
Street		City	State
4. NAME OF INJURED/INSURED PERSON		2. SOCIAL SECURITY NUMBER	6. SEX
		_____ / _____ / _____	_____
7. BIRTH DATE			
_____ / _____ / _____			
8. ADDRESS OF INJURED PERSON:			
Street		City	State
9. DATE AND TIME OF ACCIDENT		10. PLACE WHERE ACCIDENT OCCURRED	
11. WAS INJURED PERSON A: <input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Player <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____			
12. NATURE OF INJURY (INDICATE PART OF BODY INJURED – SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)			
13. DESCRIBE HOW ACCIDENT OCCURRED – GIVE ALL POSSIBLE DETAILS – MUST BE A BODILY INJURY DUE TO ACCIDENT			
14. Did accident occur (Yes or No)			15. Name of activity/sport
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			
16. The above named claimant/injured person is a regular member of the policyholder and was injured while a regular member of such team and in the manner described above.			
17. SIGNATURE (Team/League Official)		18. TITLE	19. DATE
20. MAILING ADDRESS OF TEAM / LEAGUE OFFICIAL			
Street		City	State
21. DAYTIME PHONE FOR TEAM / LEAGUE OFFICIAL		22. EMAIL ADDRESS FOR TEAM / LEAGUE OFFICIAL	
() _____			

PLEASE NOTE: American Specialty Insurance & Risk Services, Inc. also conducts business as A.S.I.R.S.I. Insurance Agency in the state of California, American Specialty Insurance & Risk Services Agency in the state of Michigan, and A.S. Insurance & Risk Services Agency in the state of New York.

Send all completed forms, itemized bills, etc. to American Specialty Insurance & Risk Services, Inc. at the address shown below:

**American Specialty Insurance & Risk Services, Inc.
Dizzy Dean Claims Administrator
P. O. Box 459
Roanoke, IN 46783
Phone: 1-800-566-7941
Fax: 260-673-1189**

E-mail: claimspa@amerspec.com



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DIZZY DEAN BASEBALL &- SOFTBALL
2012 SEASON
PROOF OF LOSS

Underwritten by: ACE American Insurance Company
POLICY NUMBER: PTP-N00720185

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Phone: 1-800-566-7941 Fax: 260-673-1189

PART II – PROOF OF LOSS (Must Be Completed By Injured Person or Parent/Guardian If A Minor)

IMPORTANT: This form must be completed in its ENTIRETY by the INJURED PERSON OR THE PARENT/GUARDIAN IF A MINOR.

1. NAME OF INJURED / INSURED PERSON		2. SOCIAL SECURITY NUMBER ____/____/____		3. SEX	4. BIRTH DATE ____/____/____
5. MAILING ADDRESS INJURED PERSON: Street _____ City _____ State _____ Zip _____					
6. DAYTIME TELEPHONE #: ()	7. IS INJURED PERSON MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. IS INJURED PERSON A MINOR? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. DATE AND TIME OF ACCIDENT		10. NAME / LOCATION WHERE ACCIDENT OCCURRED (Please include City & State)			

10. ACTIVITY PARTICIPATING IN AT TIME OF INJURY:
11. DESCRIBE INJURY (INCLUDING PART OF BODY INJURED – SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)

12. DESCRIBE HOW ACCIDENT OCCURRED – GIVE ALL POSSIBLE DETAILS – MUST BE A BODILY INJURY DUE TO ACCIDENT

13. Is injured person a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If “yes”, name of school attending:	14. If a full-time student, is student medical insurance available? <input type="checkbox"/> Yes <input type="checkbox"/> No
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15. Does injured person have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If “yes”, name of company:	16. Does parent/guardian or spouse have medical insurance for the injured person? <input type="checkbox"/> Yes <input type="checkbox"/> No If “yes”, name of company:
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17. Does injured person have Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does injured person have governmental funded insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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19. NAME & MAILING ADDRESS INJURED PERSON'S EMPLOYER:
Employer Name: _____
Street _____ City _____ State _____ Zip _____

20. NAME & MAILING ADDRESS INJURED SOUSE'S EMPLOYER: (IF APPLICABLE)
Employer Name: _____
Street _____ City _____ State _____ Zip _____

21. NAME & MAILING ADDRESS PARENT'S EMPLOYER (MOTHER):
Employer Name: _____
Street _____ City _____ State _____ Zip _____

22. NAME & MAILING ADDRESS PARENT'S EMPLOYER (FATHER):
Employer Name: _____
Street _____ City _____ State _____ Zip _____

23. AFFIDAVIT: I, the undersigned, affirm that I have not knowingly, or with intent, injured, defrauded, or deceived any insurance company by filing a statement of claim containing any false, incomplete, or misleading information, and understand I would be guilty of a felony by doing so
Signature of injured person (or parent/guardian if a minor) _____ Date Signed _____

24. AUTHORIZATION AND ASSIGNMENT OF BENEFITS:
I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.
I agree that a photographic copy of this Authorization shall be as valid as the original.
I understand that I for my authorized representative may request a cop of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

25. SIGNATURE OF CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR) _____ DATED: _____

26. MAILING ADDRESS CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR)
Street _____ City _____ State _____ Zip _____

27. DAYTIME PHONE FOR CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR) ()	28. EMAIL ADDRESS FOR CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR):
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PLEASE NOTE: American Specialty Insurance & Risk Services, Inc. also conducts business as A.S.I.R.S.I. Insurance Agency in the state of California, American Specialty Insurance & Risk Services Agency in the state of Michigan, and A.S. Insurance & Risk Services Agency in the state of New York

FRAUD STATEMENTS

GENERAL: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND / OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

CALIFORNIA

“For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

“It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.”

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

OKLAHOMA

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA

“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 any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MARYLAND / OREGON

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

VIRGINIA

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.