



1712 Magnavox Way P.O. Box 2338
 Fort Wayne, Indiana 46801
 800-237-2917 Fax (219) 459-5910
 www.kandkinsurance.com
 CA #0334819

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

PART II - TO BE COMPLETED BY LEAGUE OFFICIAL

League Name _____ Babe Ruth Team Name _____

League or Authorized _____

League Official's Address _____
 Mailing Address _____ City _____ State and Zip _____

BASEBALL	SOFTBALL	CLAIMANT IS A:	ABSENCE FROM PLAY
(Please check one.)		(Please check one.)	(Please check one.)
<input type="checkbox"/> Major Cal Ripken	<input type="checkbox"/> Major 12 & Under	<input type="checkbox"/> Player	<input type="checkbox"/> Pre-Season <input type="checkbox"/> < One Week
<input type="checkbox"/> Minor Cal Ripken	<input type="checkbox"/> Minor 12 & Under	<input type="checkbox"/> Coach	<input type="checkbox"/> Regular Season <input type="checkbox"/> 1-3 Weeks
<input type="checkbox"/> 13-15 League	<input type="checkbox"/> 16 & Under League	<input type="checkbox"/> Manager	<input type="checkbox"/> Tournament <input type="checkbox"/> 3+ Weeks
<input type="checkbox"/> 13 Prep League	<input type="checkbox"/> 18 & Under League	<input type="checkbox"/> Non-Player Personnel	
<input type="checkbox"/> 16-18 League		<input type="checkbox"/> Umpire	
<input type="checkbox"/> 16 Prep League			

Injured Person's Full Name _____ Date of Birth _____

Claimant's Social Security Number _____

Date/Hour of Accident _____ Time _____ ^{AM}/_{PM} Place Injury Occurred _____

INJURY:

INJURED BODY PART _____
 CONDITION _____
 (Laceration, Concussion, Fracture, Sprain, etc.)

SIDE:
 Left Right Both N/A
TIME:
 Morning Afternoon Evening Lights

DISPOSITION:
 On-Site Care Only
 Ambulance to _____
 City _____
 Fatality Refused Care

OCCASION:

- TO/FROM GAME
- WARMUPS
- DURING GAME (_____ Inning)
- BETWEEN INNINGS
- TO/FROM PRACTICE
- PRACTICE: (Early) (Mid) (Late)
- PRACTICE GAME CONDITIONS
- OTHER:

LOCATION:

- BASE: (1st) (2nd) (3rd) (HP)
- BASEPATH
- INFIELD
- OUTFIELD
- FOUL TERRITORY
- DUGOUT
- BULL PEN
- LOCKER ROOM
- OTHER:

ACTIVITY:

- BATTING
- RUNNING
- SLIDING
- CATCHING
- FIELDING
- TAGGING
- THROWING
- PITCHING
- OTHER:

SITUATION:

- HIT BY (Pitch) (Bat) (Foul) (Thrown Ball) (Batted Ball)
Other _____
- COLLISION WITH: (Teammate) (Opponent) (Fence)
Other _____
- NON-CONTACT INJURY
- FALL (Slip) (Trip) (Pushed)
- OTHER _____

DESCRIBE HOW ACCIDENT HAPPENED:

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. These bills must show the patient's name, condition being treated (diagnosis), type of treatment given, date the expense was incurred and the charges made.

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.

Dear 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



BEECH STREET CORPORATION



MEDICAL RESOURCE

AMERICA'S HEALTH PLAN
 DIMENSION
 FIRST CHOICE
 HEALTH CHOICE
 MANAGED HEALTHCARE NW
 MOUNTAIN MEDICAL AFFILIATES
 PREFERRED HEALTH PARTNERSHIP
 PREMIER PREFERRED CARE
 PRO-NET
 SOUTHEAST MED. ALLIANCE
 MULTIPLAN
 PREFERRED HEALTH PARTNERSHIP

ETHIX
 HEALTH CARE PREFERRED
 HEALTH CARE SAVINGS
 HEALTH NETWORK
 INTERGROUP
 MULTIPLAN
 PREFERRED HEALTH PLAN
 PREFERRED PLANS, INC
 PRIMARY HEALTH SERVICES
 SOONER HEALTH
 VIRGINIA HEALTH NETWORK

MultiPlan MULTIPLAN

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.

This 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.

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.

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

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.



An affiliate of SLE Worldwide, Inc.

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 CA (#0334819)

**BABE RUTH
 BASEBALL & SOFTBALL
 CASE REPORT**

(Check and/or circle one per section, complete relevant blanks.)

BASEBALL <input type="checkbox"/> Major Bambino <input type="checkbox"/> Minor Bambino <input type="checkbox"/> 13-15 League <input type="checkbox"/> Prep League <input type="checkbox"/> 16-18 League	SOFTBALL <input type="checkbox"/> Major 12 & Under <input type="checkbox"/> Minor 12 & Under <input type="checkbox"/> 13-15 League <input type="checkbox"/> 16-18 League	PROGRAM <input type="checkbox"/> Pre-season <input type="checkbox"/> Regular season <input type="checkbox"/> Tournament
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INJURED: (Player) (Spectator) (Coach) (Property) (Other: _____)

If player, has participant accident carrier been put on notice? Yes No

Name: _____ Age: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____

League: _____ Team: _____

League Address: _____

PLACE INJURY OCCURRED: _____

LEAGUE OFFICIAL: _____ Phone: () _____

CONTACT PERSON: _____ Phone: () _____

INJURY OR PROPERTY DAMAGE: DATE OCCURRED: _____ INJURED BODY PART: _____ CONDITION: _____ (Laceration, Concussion, Fracture, Sprain, etc.) DAMAGED PROPERTY: _____ CAUSE OF DAMAGE: _____	SIDE <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> N/A	TIME <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Lights	DISPOSITION <input type="checkbox"/> On-Site Care Only <input type="checkbox"/> Ambulance to: _____ City: _____ <input type="checkbox"/> Fatality <input type="checkbox"/> Refused Care
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OCCASION:

TO/FROM GAME
 WARMUPS
 DURING GAME
 (_____ Inning)
 BETWEEN INNINGS
 TO/FROM PRACTICE
 PRACTICE: (Early) (Mid) (Late)
 PRACTICE GAME CONDITIONS

LOCATION:

BASE: (1st) (2nd) (3rd) (HP)
 BASEPATH
 INFIELD
 OUTFIELD
 FOUL TERRITORY
 DUGOUT
 BULL PEN
 LOCKER ROOM
 GRANDSTAND SEATING
 OTHER:

ACTIVITY:

BATTING
 RUNNING
 SLIDING (Not Base-Related)
 (Fixed Base) (Break-Away Base)
 CATCHING
 FIELDING
 TAGGING
 THROWING
 HORSEPLAY
 OTHER:

AREA:

LEFT SIDE OF FIELD
 RIGHT SIDE OF FIELD
 CENTER FIELD
 BEHIND HOME PLATE
 BEYOND OUTFIELD WALL

SURFACE INVOLVED:

NOT APPLICABLE
 GRASS
 DIRT
 ARTIFICIAL
 BRICK
 WOOD
 METAL
 OTHER:

SPECIAL CIRCUMSTANCES:

NOT APPLICABLE
 PROTECTIVE EQUIPMENT
 NOT WORN
 DESPITE PROTECTIVE EQUIPMENT
 RULE INFRACTION: (Injured) (Another)
 FACILITY-RELATED (Explain)
 OTHER:

SITUATION: (Person or Property)

HIT BY: (Pitch) (Bat) (Foul)
 (Thrown Ball) (Batted Ball)
 Other:
 COLLISION WITH: (Teammate)
 (Opponent) (Public) (Fence)
 Other:
 NON-CONTACT INJURY
 FALL: (Slip) (Trip) (Pushed)
 OTHER:

DESCRIBE HOW ACCIDENT HAPPENED:

(Print)
 Respondent: _____ Phone: () _____

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. California Insurance Frauds Prevention Act 1871.2

Florida and Idaho

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. In Florida, this is a third degree felony.

Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky

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.

Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 or material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio

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 is guilty of insurance fraud.

Oklahoma

Any person who knowingly & with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony. (360.S. 5361.1)

Pennsylvania

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

COMPLETE ALL INFORMATION. FOLD IN HALF AND TAPE.



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 1768 FORT WAYNE, IN

POSTAGE WILL BE PAID BY ADDRESSEE

**Claims Department
K&K INSURANCE GROUP INC
1712 MAGNAVOX WAY
PO BOX 2338
FORT WAYNE IN 46897-1074**

