K&K INSURANCE
on behalf of Nationwide Life Insurance Company

1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
1-800-237-2917 Fax 1-260-459-5910
www.kandkinsurance.com
CA #0334819

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.

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.

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:

The First Health Network

HYGEIA

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.

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.

OVER →

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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:_____

City:_____State:_____Zip:_____

BASEBALL / SOFTBALL

(Please check one)

- ☐ Major Cal Ripken
- ☐ Minor Cal Ripken
- ☐ 13-15 League
- ☐ 13 Prep League
- ☐ 16-18 League
- ☐ 16 Prep League
- ☐ Bambino Buddy Ball
- ☐ Major 12 & Under
- ☐ Minor 12 & Under
- ☐ 14 & Under League
- ☐ 16 & Under League
- ☐ 18 & Under League

CLAIMANT IS A:

(Please check one)

- ☐ Player
- ☐ Coach
- ☐ Manager
- ☐ Non-Player Personnel
- ☐ Umpire

ABSENCE FROM PLAY

(Please check one)

- ☐ Pre-Season
- ☐ Regular Season
- ☐ Tournament
- ☐ Travel Ball
- ☐ Dual Participation
- ☐ World Series
- ☐ < One Week
- ☐ 1-3 Weeks
- ☐ 3+ Weeks

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: _____

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:_____

COMPLETE AND RETURN TO K&K, CLAIMS DEPT., P.O. BOX 2338, FORT WAYNE, IN 46801.