



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

on behalf of Nationwide Life Insurance Company

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



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
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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 reinsurance 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.



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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: _____

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"/> 14 & Under League	<input type="checkbox"/> Manager	<input type="checkbox"/> Tournament <input type="checkbox"/> 3+ Weeks
<input type="checkbox"/> 13 Prep League	<input type="checkbox"/> 16 & Under League	<input type="checkbox"/> Non-Player Personnel	<input type="checkbox"/> Travel Ball
<input type="checkbox"/> 16-18 League	<input type="checkbox"/> 18 & Under League	<input type="checkbox"/> Umpire	<input type="checkbox"/> Dual Participation
<input type="checkbox"/> 16 Prep League			<input type="checkbox"/> World Series
<input type="checkbox"/> Bambino Buddy Ball			

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:	SIDE:	TIME:	DISPOSITION:
Injured body part: _____	<input type="checkbox"/> Left	<input type="checkbox"/> Morning	<input type="checkbox"/> On-site care only
Condition: _____ (laceration, concussion, fracture, sprain, etc.)	<input type="checkbox"/> Right	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Ambulance to _____
	<input type="checkbox"/> Both	<input type="checkbox"/> Evening	_____
	<input type="checkbox"/> N/A	<input type="checkbox"/> Lights	City _____
			<input type="checkbox"/> Fatality <input type="checkbox"/> Refused care

OCCASION:	LOCATION:	ACTIVITY:
<input type="checkbox"/> TO/FROM GAME	<input type="checkbox"/> BASE: (1st) (2nd) (3rd) (HP)	<input type="checkbox"/> BATTING
<input type="checkbox"/> WARMUPS	<input type="checkbox"/> BASEPATH	<input type="checkbox"/> RUNNING
<input type="checkbox"/> DURING GAME (_____ Inning)	<input type="checkbox"/> INFIELD	<input type="checkbox"/> SLIDING
<input type="checkbox"/> BETWEEN INNINGS	<input type="checkbox"/> OUTFIELD	<input type="checkbox"/> CATCHING
<input type="checkbox"/> TO/FROM PRACTICE	<input type="checkbox"/> FOUL TERRITORY	<input type="checkbox"/> FIELDING
<input type="checkbox"/> PRACTICE: (Early) (Mid) (Late)	<input type="checkbox"/> DUGOUT	<input type="checkbox"/> TAGGING
<input type="checkbox"/> PRACTICE GAME CONDITIONS	<input type="checkbox"/> BULL PEN	<input type="checkbox"/> THROWING
<input type="checkbox"/> OTHER:	<input type="checkbox"/> LOCKER ROOM	<input type="checkbox"/> PITCHING
	<input type="checkbox"/> OTHER:	<input type="checkbox"/> OTHER:

SITUATION:	DESCRIBE HOW ACCIDENT HAPPENED:
<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 _____	

League official's name: _____ League official's signature: _____
PLEASE PRINT

Title: _____ Daytime phone: _____ Date: _____