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.
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	CLAIMANT IS A:	ABSENCE FROM PLAY	
(Please check one)		(Please check one)	(Please check one)	
☐ Major Cal Ripken	☐ Major 12 & Under	☐ Player	☐ Pre-Season	☐ < One Week
☐ Minor Cal Ripken	☐ Minor 12 & Under	☐ Coach	☐ Regular Season	☐ 1-3 Weeks
☐ 13-15 League	☐ 14 & Under League	☐ Manager	☐ Tournament	☐ 3+ Weeks
☐ 13 Prep League	☐ 16 & Under League	☐ Non-Player Personnel	☐ Travel Ball	
☐ 16-18 League	☐ 18 & Under League	☐ Umpire	☐ Dual Participation	
☐ 16 Prep League			☐ World Series	
☐ 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:

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.

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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.

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:

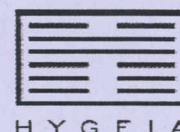
   K&K Insurance Group, Inc.
   Claims Department
   P.O. Box 2338
   Fort Wayne, IN 46801

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:



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.

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