



1712 Magnavox Way P.O. Box 2338
 Fort Wayne, Indiana 46801
 1-800-237-2917 Fax 1-312-381-9077
 www.kandkinsurance.com
 CA #0334819

on behalf of Nationwide Life Insurance Company

AMERICAN AMATEUR BASEBALL CONGRESS 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.
3. If using this insurance as your secondary insurance, attach Explanation of Benefits statements from the primary carrier.

TO THE LEAGUE/TEAM:

1. Part II must be fully completed and **signed** by the League/Team Official.
2. Make copies of the claim form after it is completed and signed by the league/team 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 \$500 per person deductible for Stan Musial participants, a \$250 per person deductible for registered umpires, a \$100 per person deductible for; T-Ball, Roberto Clemente, Willie Mays, Jackie Robinson, Pee Wee Reese, Gil Hodges, Sandy Koufax, Age 13, Mickey Mantle, Age 15, Connie Mack, and Don Mattingly.

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.

TO THE 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.
NOTE: There is a \$500 per person deductible for Stan Musial participants, a \$250 per person deductible for registered umpires, a \$100 per person deductible for T-Ball, Roberto Clemente, Willie Mays, Jackie Robinson, Pee Wee Reese, Gil Hodges, Sandy Koufax, Age 13, Mickey Mantle, Age 15, Connie Mack, and Don Mattingly.

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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AMERICAN AMATEUR BASEBALL CONGRESS ACCIDENT PROOF OF LOSS CLAIM FORM

on behalf of Nationwide Life Insurance Company

PART II – TO BE COMPLETED BY LEAGUE OFFICIAL

League/Team name: _____ AABC team name: _____

League or authorized league/team official's address: _____

City: _____ State: _____ Zip: _____

<p align="center">BASEBALL <i>(Please check one)</i></p> <input type="checkbox"/> T-Ball <input type="checkbox"/> Age 13 (13&U) <input type="checkbox"/> Roberto Clemente (8&U) <input type="checkbox"/> Mickey Mantle (16&U) <input type="checkbox"/> Willie Mays (10&U) <input type="checkbox"/> Age 15 (15&U) <input type="checkbox"/> Jackie Robinson (9&U) <input type="checkbox"/> Connie Mack (18&U) <input type="checkbox"/> Pee Wee Reese (12&U) <input type="checkbox"/> Don Mattingly (17&U) <input type="checkbox"/> Gil Hodges (11&U) <input type="checkbox"/> Stan Musial (unlimited) <input type="checkbox"/> Sandy Koufax (14&U) <input type="checkbox"/> Umpire	<p align="center">CLAIMANT IS A: <i>(Please check one)</i></p> <input type="checkbox"/> Player <input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Non-Player Personnel <input type="checkbox"/> Umpire	<p align="center">ABSENCE FROM PLAY: <i>(Please check one)</i></p> <input type="checkbox"/> Pre-Season <input type="checkbox"/> < One Week <input type="checkbox"/> Regular Season <input type="checkbox"/> 1-3 Weeks <input type="checkbox"/> Tournament <input type="checkbox"/> 3+ Weeks <input type="checkbox"/> Travel Ball <input type="checkbox"/> World Series
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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: _____

<p>INJURY:</p> <p>Injured body part: _____ Condition: _____ (laceration, concussion, fracture, sprain, etc.)</p>	<p>SIDE:</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> N/A	<p>TIME:</p> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Lights	<p>DISPOSITION:</p> <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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<p>OCCASION:</p> <input type="checkbox"/> TO/FROM GAME <input type="checkbox"/> WARMUPS <input type="checkbox"/> DURING GAME (_____ Inning) <input type="checkbox"/> BETWEEN INNINGS <input type="checkbox"/> TO/FROM PRACTICE <input type="checkbox"/> PRACTICE: (Early) (Mid) (Late) <input type="checkbox"/> PRACTICE GAME CONDITIONS <input type="checkbox"/> OTHER: _____ _____	<p>LOCATION:</p> <input type="checkbox"/> BASE: (1st) (2nd) (3rd) (HP) <input type="checkbox"/> BASEPATH <input type="checkbox"/> INFIELD <input type="checkbox"/> OUTFIELD <input type="checkbox"/> FOUL TERRITORY <input type="checkbox"/> DUGOUT <input type="checkbox"/> BULL PEN <input type="checkbox"/> LOCKER ROOM <input type="checkbox"/> OTHER: _____	<p>ACTIVITY:</p> <input type="checkbox"/> BATTING <input type="checkbox"/> RUNNING <input type="checkbox"/> SLIDING <input type="checkbox"/> CATCHING <input type="checkbox"/> FIELDING <input type="checkbox"/> TAGGING <input type="checkbox"/> THROWING <input type="checkbox"/> PITCHING <input type="checkbox"/> OTHER: _____
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<p>SITUATION:</p> <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 _____	<p>DESCRIBE HOW ACCIDENT HAPPENED:</p>
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League/Team official's name: _____ League/Team 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.

email: KK_paclaims@kandkinsurance.com • Fax: 312-381-9077

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