BASIC PROCEDURES FOR SUBMITTING A CLAIM
DIXIE BASEBALL/SOFTBALL

AMERICAN SPECIALTY

Underwriting By: ACE American Insurance Company

STEP 1 - TO THE AUTHORIZED TEAM/LEAGUE OFFICIAL

1. **Complete and sign Part 1 – Injury Report.**
2. Make and retain a copy of all documents for your records.
3. **Forward the completed Injury Report and this claim packet to the injured person or parent/guardian for completion of Part 2 - Excess Medical Insurance Claim Form and submission to the Claims Department.**

STEP 2 - TO THE INJURED PERSON OR PARENT/GUARDIAN IF A MINOR

1. **The injured participant or participant's parents/guardian should complete PART 2 - Excess Medical Insurance Claim Form.**
2. Attach current itemized physician, hospital or other provider's bills (bills must contain diagnostic codes and procedure codes) for accident medical expenses being claimed as well as the primary insurance carrier's Explanation of Benefits showing payments and denials. These bills must show the patient's name, condition being treated (diagnosis), type of treatment given, date the expense was incurred and the changes made.
3. **Claim forms will be returned if not fully completed and signed.** Omission of vital information will cause a delay in claim processing.
4. Make and retain a copy of all documents for your records
5. Send all documents **(including the completed Part 1 - Injury Report from the authorized team/league official)** to:

American Specialty Insurance Services, Inc.
ATTN: Claims Department
7609 W. Jefferson Blvd, Ste 150, Fort Wayne, IN 46804
Phone: 800-566-7941 Fax: 260-672-8835
Email: amerspec@amerspec.com

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California – For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefit and may be subject to civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

PART 1 – INJURY REPORT – DIXIE BASEBALL/SOFTBALL
TO BE COMPLETED BY AUTHORIZED TEAM OFFICIAL

Circle appropriate number and/or ( ); Fill in relevant blanks. All questions must be answered.

Name of Injured Person:	**Father's Name:**
	Father's Email:
Name of Insured Organization:	**Mother's Name:**
	Mother's Email:

Contact Information for Team Official Completing this Form:

Full Name:	**Phone #:**	**Date:**
Address (Street):	**Email Address:**	
Address (City, State, Zip):	**Signature:**	

Did Accident occur during a team-sanctioned event with adult supervision: (Yes) (No)

A. **INJURED PERSON IS:** (Player) (Coach) Other: _____

B. **AGE OF INJURED PERSON:** _____

C. **GENDER OF INJURED PERSON:** (Male) (Female)

D. **DATE OF INJURY:** _____ - _____ - _____
MONTH DAY YEAR

E. **BASEBALL / SOFTBALL PROGRAM:**
(1) Dixie Youth Buddy Ball (16&Under/Player Assisted)
(2) Dixie Youth –T-ball/Coach Pitch
(3) Dixie Youth Minors – 10 & Under
(4) Dixie Youth Majors – 12 & Under
(5) Dixie Youth O-Zone – 12 & Under
(6) Dixie Boys 13-14
(7) Dixie Pre-Majors 15-16
(8) Dixie Majors 15-19
(9) Dixie SweeTees – 6 & Under
(10) Dixie Darlings – 7-8
(11) Dixie Ponytails – 11-12
(12) Dixie Angels – 9-10
(13) Dixie Belles – 13-15
(14) Dixie Debs – 16-18
(15) Dixie 15U – 15 & Under
If Softball, please circle: (Fastpitch) (Slowpitch)

F. **INJURY OCCURRED DURING:**
(1) Traveling to/from game/practice
(2) Before game or practice
(3) After game or practice
(4) Game: _____ inning
(5) Between Innings
(6) Practice: (Early) (Mid) (Late)
(7) Practice Under Game Conditions
(8) League-Wide Recreation Outing
(9) Team Specific Recreation Outing

G. **ACTIVITY WHILE INJURED:**
(1) Batting
(2) Running
(3) Sliding: (not base related) (fixed base) (safety base)
(4) Catching: (pitched ball) (thrown ball)
(5) Fielding batted ball
(6) Tagging
(7) Throwing
(8) Pitching
(9) Stretching/Conditioning
(10) Horseplay
(11) Other: _____

H. **LOCATION WHILE INJURED:**
(1) 1st Base
(2) 2nd Base
(3) 3rd Base
(4) Home Plate
(5) Base Path
(6) Infield
(7) Outfield
(8) Mound
(9) Foul territory
(10) Dugout
(11) Bull Pen
(12) Locker Room
(13) Spectator Area
(14) Other: _____

I. **SITUATION:**
(1) Hit by Pitch: (player pitch) (coach pitch) (machine pitch)
(2) Hit by bat
(3) Hit by thrown ball
(4) Hit by batted ball
(5) Collision with teammate
(6) Collision with opponent
(7) Collision with public
(8) Collision with fence, etc.
(9) Contact with base
(10) Contact with ground: (slip) (trip) (pushed)
(11) Hand hurt catching/fielding ball – fielder
(12) Hand hurt catching ball – catcher
(13) Non contact
(14) Other: _____

J. **PRINCIPAL BODY PART INJURED:**

(1) Eye(s)	(10) Stomach	(19) Wrist
(2) Ear(s)	(11) Hip	(20) Hand
(3) Nose	(12) Groin	(21) Finger(s)/Thumb
(4) Cheek	(13) Back	(22) Thigh
(5) Chin	(14) Neck	(23) Shin
(6) Jaw	(15) Shoulder	(24) Knee
(7) Mouth/teeth	(16) Upper Arm	(25) Ankle
(8) Head	(17) Elbow	(26) Foot
(9) Chest	(18) Forearm	(27) Other: _____

K. **PRIMARY TYPE OF INJURY:**
(1) Cut/Scrape
(2) Bruise/Contusion
(3) Joint Sprain
(4) Dislocation
(5) Fracture
(6) Concussion
(7) Heat Illness
(8) Dental
(9) Pulled Muscle
(10) Other: _____

L. **SPECIAL CIRCUMSTANCES:**
(1) Safety equipment not used that might have prevented injury:
(Batter's Faceguard) (Batter's Helmet) (Safety Ball)
(Safety Base) (Fielder's Eye Goggles) (Fielder's Mouthpiece)
Other: _____
(2) Safety equipment used, but didn't prevent injury:
(Batter's Faceguard) (Batter's Helmet) (Safety Ball)
(Safety Base) (Fielder's Eye Goggles) (Fielder's Mouthpiece)
Other: _____
(3) Safety equipment used, but fell off/thrown off:
(Batter's Faceguard) (Batter's Helmet) (Catcher's Faceguard)
Other: _____
(4) Safety equipment actually contributed to injury. Explain:
_____
(5) Improperly maintained field:
(Fence not properly secured) (Rock on Field) (Hole/Rut)
Other: _____
(6) Above circumstances not applicable to injury.

M. **SEASON:** (Pre Season) (Regular Season) (Tournament)

N. **ESTIMATED ABSENCE FROM PLAYING:**
(None) (1 – 7 Days) (1 – 3 Weeks) (3+ Weeks)

O. **DESCRIBE HOW INJURY HAPPENED:**

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PART 2 – EXCESS MEDICAL INSURANCE CLAIM FORM
DIXIE BASEBALL/SOFTBALL
TO BE COMPLETED BY INJURED PERSON OR PARENT

Coverage under this policy is excess over all other valid and collectible health and accident plans. Your claim should be submitted to the insurance company providing coverage to you through your own, your parents' or your spouse's health plan, your employer or governmental health plan. After other insurance benefits have been submitted, you should forward a copy of the other insurance company's explanation of benefits and the corresponding itemized medical statements. If your insurance company denies benefits, send a copy of their denial. If there is no other valid and collectible insurance, this policy will act as primary insurance. Further details of coverage will be communicated upon receipt of this fully completed claim form.

ALL information requested on this claim form must be provided. Omission of vital information will cause delay in claim processing.

INJURED PARTICIPANT'S INFORMATION

Name: _____ Sex: _____ Date of Birth: _____/_____/_____

Social Security #: _____ Phone #: _____ Spouse's Name (if applicable): _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

FATHER OF INJURED PARTICIPANT'S INFORMATION – REQUIRED IF INJURED PARTICIPANT IS A MINOR

Name: _____ Day Phone #: _____

Cell Phone #: _____ Email Address: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Employers Name: _____ Employers Phone #: _____

Employers Mailing Address: _____ City: _____ ST: _____ Zip: _____

Group Insurance Company: _____ Policy #: _____

Insurance Company's Address: _____ City: _____ ST: _____ Zip: _____

MOTHER OF INJURED PARTICIPANT'S INFORMATION – REQUIRED IF INJURED PARTICIPANT IS A MINOR

Name: _____ Day Phone #: _____

Cell Phone #: _____ Email Address: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Employers Name: _____ Employers Phone #: _____

Employers Mailing Address: _____ City: _____ ST: _____ Zip: _____

Group Insurance Company: _____ Policy #: _____

Insurance Company's Address: _____ City: _____ ST: _____ Zip: _____

I certify that this injury occurred to a registered team member during a team/league sanctioned activity (i.e. supervised game/practice), the above information is true and accurate to the best of my knowledge and belief, and I understand fraudulent statements can be a crime.

Signature: _____ Date: _____

I waive any provision of law to the contrary and hereby authorize American Specialty Insurance Services, Inc. or its representatives to furnish to any hospital, physician or other person who has attended me, and my primary insurance carrier, any and all information with respect to the accidental injury for which I am claiming insurance benefits.

I waive any provision of law to the contrary and hereby authorize any hospital, physician or other person who has attended me, and my primary insurance carrier or employer, to furnish to American Specialty Insurance Services, Inc. any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital, medical, or insurance records including, but not limited to, information regarding other insurance coverages. I agree that a photocopy of this authorization shall be considered as effective as the original.

I understand this authorization is necessary to facilitate the obtaining and providing of proper information needed to quickly process my claim.

Signature: _____ Date: _____

PLEASE NOTE: If Injured Person is a Minor, signature must be of Parent or Legal Guardian.

PLEASE RETURN THIS FORM TO AMERICAN SPECIALTY INSURANCE SERVICES, INC. PER COVER PAGE INSTRUCTIONS