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 1-312-381-9077
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 II 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. Attach Explanation of Benefits statements from the primary carrier.

### TO THE LEAGUE:

1. Part I 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**

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:

The First Health Network

HYGEIA

### PLEASE 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.**
- **Claim form must be submitted within 15 months from injury date.**

**Applicable in Arizona**

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington and West Virginia**

Any person who knowingly and with intent to defraud any insurance company or another person, files a 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, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied.

**Applicable in California**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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.

**Applicable in 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 or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Applicable in Florida and Idaho**

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.*
* In Florida - Third Degree Felony

**Applicable in Hawaii**

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Applicable in Indiana**

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Applicable in Minnesota**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Applicable in Nevada**

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

**Applicable in New Hampshire**

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**Applicable in Ohio**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Applicable in Oklahoma**

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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# BABE RUTH LEAGUE, INC. ACCIDENT PROOF OF LOSS CLAIM FORM

## PART I – TO BE COMPLETED BY LEAGUE OFFICIAL

League name: KINGSTON YOUTH BABE RUT Babe Ruth team name: _____

League or authorized league official's address: DBA KYBSL; 12 BROOKDALE ST.

City: KINGSTON State: MA Zip: 02364

**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: _____

Insured person's full address: _____

Claimant's social security number: _____ Date/hour of accident: _____ Time: _____ A.M. / P.M.

**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: _____
*Please Print*

League official's signature: _____

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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# BABE RUTH LEAGUE, INC. ACCIDENT MEDICAL INSURANCE CLAIM FORM

## PART II – TO BE COMPLETED BY INJURED PERSON OR PARENT

### IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED. OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

**COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER HEALTH & ACCIDENT INSURANCE AVAILABLE. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL 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 INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. NOTE: COVERAGE MAY ALSO INCLUDE A POLICY DEDUCTIBLE.**

***WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM***

INJURED PERSON:_____

FATHER'S NAME (if injured is a minor)_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

GROUP INSURANCE COMPANY:_____

POLICY NUMBER:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY NUMBER:_____

SIGNATURE:_____

SPOUSE'S NAME (if applicable):_____

MOTHER'S NAME (if injured is a minor)_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

GROUP INSURANCE COMPANY:_____

POLICY NUMBER:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY NUMBER:_____

SIGNATURE:_____

**I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY 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 INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES 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 INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.**

SIGNED:_____ DATE:_____

***Please Note: If injured person is a minor, signature must be of parent or legal guardian.***