

Complete & Return this Form to:

Medical/Dental Accident Claim Form

USA Softball
District 31
5215 Ave A
Santa Fe, TX 77510



UMPIRE

\$250 Deductible 90/10 co-insurance

52-week benefit period

SECTION I TO BE COMPLETED BY CLAIMANT (Required)

1. NAME: (first) _____ (last) _____

2. ADDRESS: _____ (city) _____ (state) _____ (zip code) _____

3. TELEPHONE #: _____

4. BIRTHDATE: ___/___/___ SEX: Male Female SS#: _____

5. FASTPITCH SLOWPITCH

6. YOUTH ADULT

7. ASA EVENT? YES NO IF NO, PLEASE SPECIFY: _____

8. ACCIDENT DATE: ___/___/___ ACCIDENT TIME: _____ am pm

9. BODY PART INJURED: _____

10. ACCIDENT OCCURRED DURING: Game Practice Tournament Camp/Clinic Other _____

11. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: _____

12. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED: _____

PLEASE NOTE: THIS FORM CANNOT BE SUBMITTED WITHOUT THE REQUIRED SIGNATURE

SECTION II VERIFICATION (Must be signed by ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner) Policy#:4102AH222098

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS A REGISTERED UMPIRE WITH THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF ASA STATE/METRO COMMISSIONER: _____ TITLE: _____

SIGNATURE OF ASA STATE/METRO COMMISSIONER: _____ DATE: _____

SECTION III STATEMENT OF OTHER INSURANCE (Required)

Claimant

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
EMPLOYER NAME: _____
EMPLOYER PHONE: _____
SELF EMPLOYED UNEMPLOYED
EMAIL: _____

If you are employed but have no insurance, you must include a letter of verification from your employer on their letterhead that no insurance is provided to you through your workplace.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NO
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES NO

INSURED NAME: _____ ID#: _____ INSURED GROUP# /NAME: _____
INSURANCE COMPANY NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

SECTION IV AUTHORIZATION REGARDING PAYMENT OF BENEFITS

ALL CLAIM BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING PROVIDED INDICATES PAYMENT MADE BY YOU.

SECTION V STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required): _____ DATE: _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by RPS Bollinger or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT (required): _____ DATE: _____