



**LITTLE LEAGUE® BASEBALL AND SOFTBALL  
ACCIDENT NOTIFICATION FORM  
INSTRUCTIONS**

## Accident & Health (U.S.)

1. This form must be completed by parents (if claimant is under 19 years of age) and a league official and forwarded to Little League Headquarters within 20 days after the accident. A photocopy of this form should be made and kept by the claimant/parent. Initial medical/dental treatment must be rendered within 30 days of the Little League accident.
2. Itemized bills including description of service, date of service, procedure and diagnosis codes for medical services/supplies and/or other documentation related to claim for benefits are to be provided within 90 days after the accident date. In no event shall such proof be furnished later than 12 months from the date the medical expense was incurred.
3. When other insurance is present, parents or claimant must forward copies of the Explanation of Benefits or Notice/Letter of Denial for each charge directly to Little League Headquarters, even if the charges do not exceed the deductible of the primary insurance program.
4. Policy provides benefits for eligible medical expenses incurred within 52 weeks of the accident, subject to Excess Coverage and Exclusion provisions of the plan.
5. **Limited** deferred medical/dental benefits may be available for necessary treatment incurred after 52 weeks. Refer to insurance brochure provided to the league president, or contact Little League Headquarters within the year of injury.
6. Accident Claim Form must be fully completed - including Social Security Number (SSN) - for processing.

**Send Completed Form To:**  
Little League® International  
539 US Route 15 Hwy. PO Box 3485  
Williamsport PA 17701-0485  
**Accident Claim Contact Numbers:**  
Phone: 570-327-1674

League Name		League I.D.	
Name of Injured Person/Claimant		SSN	PART 1
			Date of Birth (MM/DD/YY)
			Age
			Sex
			<input type="checkbox"/> Female <input type="checkbox"/> Male
Name of Parent/Guardian, if Claimant is a Minor		Home Phone (Inc. Area Code)	Bus. Phone (Inc. Area Code)
		(      )	(      )
Address of Claimant		Address of Parent/Guardian, if different	
<p>The Little League Master Accident Policy provides benefits in <b>excess</b> of benefits from other insurance programs subject to a \$50 deductible per injury. "Other insurance programs" include family's personal insurance, student insurance through a school or insurance through an employer.</p>			

The Little League Master Accident Policy provides benefits in **excess** of benefits from other insurance programs subject to a \$50 deductible per injury. "Other insurance programs" include family's personal insurance, student insurance through a school or insurance through an employer for employees and family members. Please CHECK the appropriate boxes below. If YES, follow instruction 3 above.

Does the insured Person/Parent/Guardian have any insurance through: Employer Plan  Yes  No School Plan  Yes  No  
Individual Plan  Yes  No Dental Plan  Yes  No

Date of Accident	Time of Accident	Type of Injury
	<input type="checkbox"/> AM <input type="checkbox"/> PM	

Describe exactly how accident happened, including playing position at the time of accident:

Check all applicable responses in each column:

BASEBALL       CHALLENGER (4-18)       PLAYER       TRYOUTS       SPECIAL EVENT (NOT GAMES)  
 SOFTBALL       T-BALL (4-7)       MANAGER, COACH       PRACTICE       SPECIAL GAME(S)  
 CHALLENGER       MINOR (6-12)       VOLUNTEER UMPIRE       SCHEDULED GAME  
 TAD (2ND SEASON)       LITTLE LEAGUE(9-12)       PLAYER AGENT       TRAVEL TO  
       INTERMEDIATE (50/70) (11-13)       OFFICIAL SCOREKEEPER       TRAVEL FROM  
       JUNIOR (12-14)       SAFETY OFFICER       TOURNAMENT  
       SENIOR (13-16)       VOLUNTEER WORKER       OTHER (Describe)  
(Submit a copy of your approval from Little League Incorporated)

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information contained is complete and correct as herein given.

I understand that it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s). See Remarks section on reverse side of form.

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, or our health, to disclose, whenever requested to do so by Little League and/or National Union Fire Insurance Company of Pittsburgh, Pa. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date	Claimant/Parent/Guardian Signature (In a two parent household, both parents must sign this form.)
Date	Claimant/Parent/Guardian Signature