MARKEL INSURANCE COMPANY
Glen Allen, VA.

Accident Only
Proof Of Insurance
Blanket Accident Policy 4102AH220317-16

Maywood Girls SB LG
Brian Bulger
35 Oak Street
Rochelle Park, NJ 07662

Effective Date:	See Attached
Expiration Date:	01/01/17
Classification:	12 & Under
Number of Teams:	9

YOU ARE INSURED UNDER AN ACCIDENT-ONLY POLICY. THE POLICY DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.

We, the Markel Insurance Company, have issued a Blanket Accident-Only Policy to the Policyholder:

AMATEUR SOFTBALL ASSOCIATION OF AMERICA

You are covered by the Blanket Accident Policy while you are a member of the class of Covered Persons described below. You should read this Certificate with care in order to understand the coverages provided

SCOPE OF COVERAGE: Accident policy benefits are outlined below:

Accidental Death Benefit	Accidental Dismemberment Benefit Principal Sum	Medical/Dental Expense Benefits Maximum Limit	Deductible
$5,000	$10,000	$250,000	$250

Additional benefits and conditions of coverage:

a. **52-week benefit period:** Eligible expenses for treatment are covered for 52 weeks from the date of injury. Any expenses incurred beyond the benefit period are not covered by this policy.
b. 90/10 Coinsurance.
c. Medical and Dental services must begin within 60 days from the date of injury.
d. Claim must be submitted to Bollinger within 90 days or up to one year from the date of injury to be eligible for payment.
e. Deductible is a "corridor" deductible, which applies regardless of payments by other primary insurance.
f. Claims are paid based on a Usual and Customary Basis which means Expenses (a) charged for treatment, supplies or medical services which are Medically Necessary to treat the Insured's condition; and (b) which do not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where incurred.
g Physical Therapy/Chiropractic limit: $2,500 limit per injury, limited to $100 maximum per visit
h. Durable Medical Equipment limit: $1,000 per injury
i. Prescription Drug Limit: $1,000 per injury

Covered Injuries: We will pay the benefits described for injuries to the body:

a) Caused by an accident which happens while you are a covered person under the policy; and
b) Which directly, and from no other cause, result in a covered loss.

Covered Persons: All persons who are currently registered as participants or adult supervisors of the Amateur Softball Association and all persons added to the team/league during the policy term are Covered Persons.

Covered Events: We will cover injuries to a Covered Person while taking part in:

(1) A regularly scheduled game or practice of the Policyholder's team or league; and
(2) Authorized tournaments, Post Season or Exhibition games or practice; and
(3) Group travel as a team under the supervision of team authorities directly to or from such games or practices held away from the teams' home field.
(4) Other incidental activities sponsored by and usual to the operation of a team or league, such as banquets and non-hazardous fundraisers.

This certificate is a summary of benefits provided under this policy. Nothing contained herein shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the actual Policy.

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Glen Allen, VA.

Accident Only
Proof Of Insurance
Blanket Accident Policy 4102AH220317-16

Maywood Girls SB LG
Brian Bulger
35 Oak Street
Rochelle Park, NJ 07662

Effective Date:	See Attached
Expiration Date:	01/01/17
Classification:	13 to 19
Number of Teams:	3

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b. 90/10 Coinsurance.
c. Medical and Dental services must begin within 60 days from the date of injury.
d. Claim must be submitted to Bollinger within 90 days or up to one year from the date of injury to be eligible for payment.
e. Deductible is a "corridor" deductible, which applies regardless of payments by other primary insurance.
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(2) Authorized tournaments, Post Season or Exhibition games or practice; and
(3) Group travel as a team under the supervision of team authorities directly to or from such games or practices held away from the teams' home field.
(4) Other incidental activities sponsored by and usual to the operation of a team or league, such as banquets and non-hazardous fundraisers.

This certificate is a summary of benefits provided under this policy. Nothing contained herein shall be held to vary, alter, waive or extend any of the Agreements, Conditions, Declarations, Exclusions, Limitations or Terms of the actual Policy.

Team Listing

Insured:

Maywood Girls SB LG
Brian Bulger
35 Oak Street
Rochelle Park, NJ 07662

Policy #: 4102AH220317-16

Certificate #: 52896

Policy Effective Date: See Below

Policy Expiration Date: 1/1/2017

Teams with Accident Only

Covered Teams

EFFECTIVE DATE	TEAM NAME	EFFECTIVE DATE	TEAM NAME	EFFECTIVE DATE	TEAM NAME
01/01/2016	Travel 10u Team Bulger	01/01/2016	Travel 12u Team Hopkins	01/01/2016	Team Hopkins - Tennessee Voluntee
01/01/2016	Team Rust - Arizona State Sundevils	01/01/2016	Team Flores - Georgia Bulldogs	01/01/2016	Team Leston - Georgia Tech Yellow J
01/01/2016	Team Stelter - Arizona Wildcats	01/01/2016	Team Taylor - Kansas Jayhawks	01/01/2016	Team Bulger - Pepperdine Wave
01/01/2016	Travel 14u - Team DeGuzman	01/01/2016	Darren Sloan - Arizonal State Sun Devils	01/01/2016	Von DeGuzman - Washington Hurrica

COMPLETE AND RETURN THIS FORM TO:

RPS PROGRAMS
BOLLINGER SPORTS & LEISURE

P.O. Box 390 Short Hills, NJ 07078

Medical/Dental Accident CLAIM FORM

ASA USA Softball
THE NATIONAL GOVERNING BODY OF SOFTBALL

TEAM

90/10 co-insurance **52 week benefit period**

SECTION I TO BE COMPLETED BY PARENT/CLAIMANT (required)

1. **NAME:** (first) _____(last) _____
2. **ADDRESS**: _____(city) _____(state) _____(zip code)_____
3. **TELEPHONE #:**_____ **SS#:**_____
4. **BIRTHDATE:** ___/___/___ **SEX:** ☐ Male ☐ Female **FASTPITCH** ☐ **SLOWPITCH** ☐
5. **CLAIMANT IS:** ☐ Youth ☐ Coach/Manager ☐ Other_____
6. **NAME OF TEAM:**_____
7. **NAME OF INSURED:** Maywood Girls SB LG
8. **ACCIDENT INSURANCE ID#:**_____
9. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ ☐ am ☐ pm
10. **BODY PART INJURED:**_____
11. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Other _____
12. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____

_____

13. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**_____

Deductible:	$250.00
Plan Year:	01/01/2016
Certificate#:	52896

****IF THIS SECTION IS NOT FILLED OUT, BOLLINGER CANNOT PROCESS AND WILL RETURN CLAIM FORM****

SECTION II VERIFICATION (Must be signed by Team/League Official) Policy #:4102AH220317

I CERTIFY THAT THE ABOVE NAMED CLAIMANT IS AN INSURED MEMBER OF THE TEAM NAMED ABOVE AND THAT THE INJURY OCCURRED DURING OFFICIAL TEAM ACTIVITIES AS STATED.

NAME OF TEAM/LEAGUE OFFICIAL: _____ TITLE: _____

SIGNATURE OF TEAM/LEAGUE OFFICIAL: _____ DATE:_____

PHONE: _____

SECTION III VERIFICATION (Must be signed by ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner)

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS ON A REGISTERED TEAM 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: _____

PHONE: _____

Was this injury a result of an ASA event? [ ] YES [ ] NO If no, indicate name of Organization that held event: _____

SECTION IV STATEMENT OF OTHER INSURANCE (Required)

Father/Claimant

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____ ZIP:_____

PHONE:_____

EMPLOYER:_____

PHONE:_____

SELF EMPLOYED ☐ UNEMPLOYED ☐

EMAIL:_____

Mother/Claimant

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____ ZIP:_____

PHONE:_____

EMPLOYER:_____

PHONE:_____

SELF EMPLOYED ☐ UNEMPLOYED ☐

EMAIL:_____

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

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

POLICY HOLDER NAME: _____ ID#:_____ INSURED GROUP# /NAME:_____

INSURANCE COMPANY NAME:_____

ADDRESS:_____

CITY:_____ STATE: _____ ZIP:_____

PHONE:_____

****Please include a copy of insurance card (both sides)**

NOTE: IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY: _____

_____

SECTION V ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

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

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantia civil penalty to the extent allows by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF PARENT/CLAIMANT (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 Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

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

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. If you receive Government or State Aid Insurance (Medicaid, Medicare, etc) this insurance may be Primary; please contact RPS Bollinger for coverage information.

    - Payment under this policy will be made according to **usual and customary guidelines.** This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **1 year** from date of injury to submit claim form.
   For claims to be eligible for coverage, you must seek medical attention within **60 days** from date of injury and **180 days** from date of injury for dental treatment.

   Benefit Period: This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**
   a) **Only submit the Claim Form to RPS Bollinger**
   b) Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to RPS Bollinger
   c) **Itemized bills are required**: You or your providers must submit itemized bills with your primary insurance explanation of benefits (if applicable); balance due bills or notices **do not** provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

    - **CMS-1500** is the standard form used by Providers to show the medical treatments and charges made for each service.
    - **UB-04** is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy. Please have your provider submit an ADA dental claim form with the explanation of benefits (if applicable).

For further information contact:

RPS Bollinger, Sports Claims Department
P.O. Box 390 Short Hills, NJ 07078
(P) 866.267.0093
(F) 973.921.2876
SportsClaims@RPSins.com

RPS PROGRAMS
BOLLINGER SPORTS & LEISURE

Fraud Statements

GENERAL: 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.

ALASKA: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

ARKANSAS: 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.

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 the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA RESIDENTS: **WARNING**: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other 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.

LOUISIANA: 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.

MAINE: 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 or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

NEW HAMPSHIRE: Any person who, with a 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: 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 civil fines and criminal penalties.

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.

OHIO: Any person who, with intent to defraud or knowing that he 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.

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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

RHODE ISLAND: 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.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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 include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA: 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.