Complete & Return this Form to:

Medical/Dental Accident Claim Form

USA Softball
District 31
PO Box 2427
Texas City, TX 77592

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:____________