Complete & Return this Form to:

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

Medical/Dental Accident Claim Form

Individual Registration

90/10 co-insurance

52-week benefit period

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN (Required)

1. **NAME:** (first) _____ (last)_____
2. **ADDRESS**: _____ (city) _____ (state) _____ (zip code)_____
3. **TELEPHONE #**:_____
4. **BIRTHDATE:** ___/___/___ **SEX:** ☐ Male ☐ Female **SS#:**_____
5. **CLAIMANT IS A:** ☐ **YOUTH** ☐ **COACH/MANAGER** ☐ **OTHER:**_____
6. **NAME OF LEAGUE AND NAME OF TEAM:**_____
7. **TOURN NAME:**_____ **TYPE:**_____ **DIRECTOR NAME & #:**_____
8. **ASA ID CARD #:** _____ **(Include copy of card)** **FASTPITCH** ☐ **SLOWPITCH** ☐
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:**_____

SECTION II VERIFICATION TEAM/LEAGUE OFFICIAL SIGNATURE (Required) **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 ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner Signature (Required)

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

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

SIGNATURE OF ASA STATE OR METRO COMMISSIONER:_____ DATE: _____ PHONE: _____

Check deductible option selected for player/clmt at the time of registration: $125_____ $250_X_ $500_____

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:_____

EMAIL:_____

SELF EMPLOYED ☐ UNEMPLOYED ☐

Mother/Claimant

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____ ZIP:_____

PHONE:_____

EMPLOYER:_____

PHONE:_____

EMAIL:_____

SELF EMPLOYED ☐ UNEMPLOYED ☐

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

INSURED NAME:_____ ID#:_____ INSURED GRP#/NAME:_____

INSURANCE COMPANY NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____

****ARE YOU INSURED WITH ANY OTHER SOFTBALL ORGANIZATION. ☐ YES ☐ NO**
IF YES, INDICATE THE ORGANIZATION, CONTACT PERSON'S NAME & PHONE NUMBER:

_____

*Please include 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 BILLING INDICATES PAYMENT MADE BY YOU.

SECTION VI 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 its 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/PARENT (required):_____ **DATE:**_____