


NOTICE

WARNING: 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 may be a crime.

PART A – This PART MUST be completed, dated and signed by an official of the Organization.			
1. Name of Organization (Policyholder) Chicago North Men's Senior Baseball League dba CNMSBL			
2. Policy No. BAP-101271-1			
3. Name of Organization or Team (if different from Policyholder) CNMSBL			
4. Address of Organization (Street) 4432 N. CLIFTON 3N		4. Address of Organization (City) CHICAGO	4. Address of Organization (State) IL
			4. Address of Organization (Zip) 60640
5. Name of Injured Person (Insured) (First)		5. Name of Injured Person (Insured) (Middle)	5. Name of Injured Person (Insured) (Last)
6. Date of Accident/Injury Mo Day Year / /		7. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other _____	8. Type of Sport or Activity: Baseball
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.			
10. Describe the nature of injury.			
11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>		12. Name of Supervisor of Activity	13. Was he/she a witness to Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Signature of Organization Official X 		15. Title of Official President #	16. Area Code/Telephone No. (773) 769-2213
			17. Date Signed

PART B – This PART MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM

Check one: Injured Person Parent Guardian

Give the following information about the Injured Person:

1. Date of Birth Mo Day Year / /	2. Male <input type="checkbox"/> Female <input type="checkbox"/>	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ()
-------------------------------------------------------	---------------------------------------------------------------------	--------------------------------------------------------	----------------------------------------

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
()

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes No

If YES, give the following information:

Name of Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)
------------------------------------	---------------------------------------	------------------	-------------------------

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

Name of Mother or Female Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

9. If the Injured Person is married, give the following information:

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

X _____
Signature (in writing) of Responsible Party

Print Name

Check one: Injured Person
 Parent
 Guardian
Date: _____

Mailing The Claim

When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

The Loomis Company
PO Box 14162
Reading, PA 19612-4162

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (866) 915-6618

Documents may also be faxed to the claims office at (630) 665-7294. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanations of benefits are available for reimbursement.

ACCIDENT DEDUCTIBLE CREDIT SHEET

INJURED'S NAME: _____

POLICYHOLDER'S NAME: Chicago North Men's Senior Baseball League
DBA CNMSBL

DATE OF INJURY: _____

NAME & ADDRESS CHECK SHOULD BE SENT TO:

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your request, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.