To All Mendon Jr. Baseball and Softball Coaches,

The sports of baseball and softball bring with it, as does any other sport, the possibility of injury. Although we do our best to avoid it, it does happen. As such, the league provides insurance coverage to all participants. This insurance is meant to be secondary to whatever insurance the player's parents or guardians already have in place. In other words, it takes over only after all benefits to which the player is entitled to from his/her primary insurance runs out. An example would be any deductible that might be in place which would normally have to be paid out of pocket.

To ensure that any injured players receive any/all benefits to which he/she is entitled under the league insurance program it is important that the proper process is followed.

1. Ensure that there are at least 2 copies of the claim form (attached as the last page of this document) at each practice and game whether by your or one of the other coaches or assistant coaches.
2. In the case of an injury of any kind whether you think the player will require medical attention or not complete the claim form with as much of the information as you can. Some of the information clearly requires parental completion.
3. Give the form to the player's parent or guardian.
4. Instruct the parent or guardian to complete the balance of the form and mail the address at the top right hand corner of the form in the event that he/she requires medical attention whether or not the parent or guardian believes that the player is completely covered with their primary insurance.

Adherence to this process will ensure that when/if there are charges above and beyond the primary insurance coverage it will be taken care of in a timely manner. Please direct all questions regarding this process or the insurance coverage in general to Rich Schofield at (508) 958-2958. Thanks in advance and have a great season!

Rich Schofield

Treasurer and Registrar – Mendon Jr. Baseball / Softball

ACORD TM

CERTIFICATE OF LIABILITY INSURANCE

Date (mm/dd/yy) 11/30/2007

PRODUCER 1-804-733-2020

CHAPPELL INSURANCE AGENCY
25807-A COX ROAD
PETERSBURG, VA 23803

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

PLAYERS CHOICE SPORTS ASSOCIATION, INC.
302 FERRY ST.
DAYTON, OR 97114

INSURERS AFFORDING COVERAGE	
INSURER A:	**MT. HAWLEY INSURANCE CO.**
INSURER B:	**FEDERAL INSURANCE COMPANY**
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSION AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	**GENERAL LIABILITY** X COMMERCIAL GENERAL LIABILITY CLAIMS MADE [X] OCCUR X PLL-$2,000,000 GEN'L AGGREGATE LIMIT APPLIES: POLICY / PROJECT / LOC	CCP459369	01/01/08	01/01/09	EACH OCCURRENCE	$ 2,000,000
					FIRE DAMAGE(any one fire)	$ 300,000
					MED EXP (any one person)	$ EXCLUDED
					GENERAL AGGREGATE	$ 2,000,000
					PERSONAL ADV INJURY	$ 2,000,000
					PRODUCTS - COMP/OP AGG	$ 2,000,000
B	**OTHER** SECONDARY PARTICIPANT ACCIDENT	MPE 0005093	01/01/08	01/01/09	$100,000 LIMIT $250 Deductible	
	EXCESS LIABILTY CLAIMS MADE / OCCUR				EACH OCCURRENCE	$
					AGGREGATE	$

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENTS/SPECIAL PROVISIONS

COVERAGE INCLUDES AMATEUR PLAY AND PRACTICE IN THE INSURED SPORT. TEAM OR LEAGUE LISTED BELOW IS A NAMED INSURED UNDER ABOVE REFERENCED PLAYERS CHOICE POLICIES.

COVERAGE IS EFFECTIVE 1/1/2008.

CERTIFICATE HOLDER | **ADDITIONAL INSURED; INSURER LETTER ___**

MENDON JR BASEBALL-SOFTBALL (2)Teams
P.O. BOX 128
MENDON, MA 01756

CERTIFICATE #: BB-10-31

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

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Call 800-557-6794 for Facilities Referral

1. **Please fully complete this form**
2. **Attach Itemized bills**
3. **Mail to --------->**

E-mail: claims@hsri.com

HSR Plaza
4001 N. Josey Lane Carrollton, Texas 75007
Phone: (972) 492 - 6474 Fax: (972) 492 - 4946
800-328-1114 Option

Policy Number:
_____9906-2235__________

MENDON JR BASEBALL-SOFTBALL

BB-10 - 31

PART I - POLICYHOLDER'S REPORT

1. Name of policy holder
2. Address of policy holder
   Street City State ZIP

3. Name of insured person | 4. Social Security Number - - | 5. Sex _____M _____F | 6. Birthday ____/____/____

7. Address of Insured Person
Street City State

8. Parents Name, Address and Phone Number (Include area code) ZIP

9. Date and time of accident | 10. Place where accident occurred | 11. Was insured a participant, staff member, guest or volunteer?

For Dental Claims only
12. Indicate which teeth were involved in the accident
13. Describe condition of teeth prior to accident: ☐ Whole, sound and natural ☐ Filled ☐ Capped ☐ Artificial

14. Nature of Injury (indicate part of body injured - such as broken arm, sprained ankle, etc)

15. Describe how accident occurred - give all possible details - must be a bodily injury due to accident

16. Did accident occur (circle yes or no) for each of the following:

A. During a policyholder sponsored & supervised activity?	Yes	No
B. During programmed hours?	Yes	No
C. On activity Premises?	Yes	No
D. While on the job (if applicable)?	Yes	No
E. While traveling directly and uninterruptedly to or from home and policy holder premises?	Yes	No
F. During intercollegiate/scholastic athletic practice? Yes NO or competition?	Yes	No
G. During a sanctioned event?	Yes	No

17. Name of event or activity | 18. Name and Title of Supervisor

19. Signature of policyholder representative | 20. Title | Date

PART II - OTHER INSURANCE STATEMENT

Do you/Spouse/Parent have medical/health coverage through your employer or other source to you? Yes No
If Yes, name of insurance company ______________________________ Policy # ____________________

Is the claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), or similiar prepaid health care plan, or any type of accident /health/sickness plan? If Yes, name of insurance company __________________________ Policy # ________________ Yes No

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:
If Yes, name of insurance company ______________________________ Policy # ____________________

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES or their EXPLANATION OF BENEFITS along with your claim form.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ AND SIGN BELOW
I agree that should it be determined at a later date there is insurance (or similiar), to reimburse HEALTH SPECIAL RISK, INC. or the insurance company to the extent of any amount collectible

Signature of Parent or Participant	Witness	Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

Signature ______________________________ Date __________

I hereby authorize any insurance company, hospital, physician or the person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consulation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature ______________________________ Date __________