

Did the owner have a representative on site when this happened?

Who owns the premises where this happened?

What is this persons position with the organization?

Who was in charge at the time of the occurrence?

How did it happen? (be specific)

Location of occurrence (where did it happen?)

Type of occurrence (accident, injury, property damage etc.)

Date reporting occurrence

Date of occurrence Time of occurrence

PART I – To be filled in by all persons reporting an incident.

PLEASE NOTE: This report is designed to establish an immediate record of any incident that may evolve into some further action being taken, such as, but not limited to, an insurance claim or legal action. It is to assist all parties in the preparation of any documents required to explain or support the incident, accident or claim referred to herein. Baseball Ontario strongly recommends that all Local Associations make all of their personnel aware of this report and require that any incidents be reported within 24 hours of the occurrence.

INCIDENT REPORT

3-131 Sheldon Drive, Cambridge, Ontario, N1R 6S2
Phone: 519-740-3900 Fax: 519-740-6311
baseball@baseballontario.com www.baseballontario.com



PART II - To be filled out by persons reporting an accident or occurrence where someone is injured.

Name of injured party _____ Age _____ Sex _____
Address _____
City _____ Postal Code _____
Telephone Numbers () () _____
In the case of a child, who is the responsible party for the injured party? _____
Address as above _____ Other _____
City _____ Postal Code _____ Tel. #'s _____
Nature of Injury (What was injured?) _____
Status of Injured Party. (competitor, coach, spectator etc.) _____
What was the probable cause of this accident? _____
Was First aid given? _____ By Whom? _____
Nature of treatment given _____
Did patient require medical/dental etc. treatment? _____ How was the patient transported to the treatment centre? _____ Where was the patient treated? _____
By Whom? (name of Doctor/Dentist etc.) _____

SEE PAGE 4 OF THIS REPORT FOR FURTHER DETAILS AND SIGNATURE

PART III - To be filled out by persons reporting an accident or occurrence where there is damage to property.

Owner of damaged property.

Address

City Postal Code Phone Numbers

Description of damaged property

What caused this damage? (Baseball, car, bicycle etc)

Describe how this happened?

Were police called? If "Yes" Officers Name

Badge Number Detachment Incident #

Were there any witnesses?

Name of Witness

Address

City Postal Code Phone Numbers

What were the weather conditions at the time?

Was the weather a factor in this event?

Other Insurance Held (Accident, Extended Health, Travel etc)

Insurer

Policy # Type of Policy



ATHLETIC ACCIDENT CLAIM FORM - INSTRUCTIONS

You must provide all information requested, incomplete claim forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Ford-Dunn Insurance Brokers must receive notice of your accident within 30 days of the accident date, and receive claim documentation within 90 days.

2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
 - > patients= name
 - > type of purchase or service
 - > date of each purchase or service
 - > amount charged for each purchase or service

3. A physician statement confirming diagnosis and recommended treatments are required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible, specified in your plan details, will be considered for payment up to your maximum benefits.

5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.

XIF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:

(Please check your plan details for the conditions under which these benefits are eligible, You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

- A. PRESCRIBED DRUGS
 - > name of medication or drug
 - > date of purchase
 - > amount charged

- B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
 - > physician referral
 - > type of service
 - > date of each treatment
 - > amount charged for each treatment
 - > dates of treatments paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

- C. HOSPITAL ROOM ACCOMMODATION
 - > not an eligible expense

- D. AMBULANCE (Emergency to Hospital only)
 - > date of service
 - > places ambulance taken from and to
 - > amount charged

- E. VISION CARE
 - > if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to an accident
 - > an explanation must be submitted with your receipt to claim the limited benefit

- F. SCHEDULED FRACTURE INDEMNITY
 - > if your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable.
 - > a statement completed by the licensed physician or surgeon confirming the fracture/dislocation

- G. MEDICAL BRACES
 - a letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed, must be submitted with your receipt
 - > medical braces required primarily for sporting type activities are not covered

- H. DENTAL ACCIDENTS
 - > exact date of accident
 - > a breakdown of services performed
 - > circumstances surrounding the accident
 - > is there other dental coverage? Enclose details
 - > confirmation that treatments only relate to the accident
 - > provide other insurer=s explanation
 - > are further treatments estimated?

- I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
 - > your Sports Accident Policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not.

YOUR SPORTS ACCIDENT POLICY MAY INCLUDE A DEDUCTIBLE AND/OR A PERCENTAGE OF REIMBURSEMENT. (Example: \$100.00 deductible or \$30 per treatment up to \$300 per accident.) IF IN DOUBT, CHECK WITH FORD-DUNN INSURANCE FOR DETAILS.

ATHLETIC ACCIDENT CLAIM FORM - PHYSICIAN'S STATEMENT

Note: Please do not submit claims for medical expenses covered under a Government or other Health Plan.

Full Name of Insured: _____ Birthdate: _____

Address: _____

If a Minor - Name of Parent: _____ Telephone: _____

Date of accident: _____ Hour: _____ am pm

Location of accident: _____

Nature of injury: _____

If taken to hospital, name of hospital: _____

Date of admittance: _____ Hour: _____ am pm

Date of discharge: _____ Hour: _____ am pm

Attending Physician or Dentist's name: _____

Address: _____

Describe fully how the accident occurred: _____

Is there coverage under any other insurance or benefit plan? _____

Name of Company or Institution: _____

Address: _____

Policy No: _____ Certificate No: _____

Signature: _____ Date: _____

Certificate of Association or Club Executive

Name of Team:		League or Association:		Group Policy Number:	
Was the above player a registered member at the time of injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		On what date did the Insured join the team or Association? _____		Name of Sport: _____	
Was player injured while taking part in an authorized practice or activity? Yes <input type="checkbox"/> No <input type="checkbox"/>		An authorized League game? Yes <input type="checkbox"/> No <input type="checkbox"/>		Position: _____	
Address: _____		Telephone: _____		Signature: _____	

Please remit this form to:

Pearson-Dunn Insurance Brokers Inc.
Representative for All Sport Insurance Marketing Ltd.
260 Nebo Rd, Hamilton, ON, L8W 3K5
Tel. 905-522-6871 or 1-800-461-5087 Fax 905-575-4250

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____

Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated: _____

If hospitalized, give name of hospital: _____

Date Admitted: _____

Date Discharged: _____

If referred to you, give name of referring physician: _____

Operations (or other procedures) performed: _____

Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____

Has the patient ever had same or similar condition? _____

If "Yes" please state when and describe: _____

Is there any other disease or infirmity affecting the present condition? _____

Signature (MD): _____

Date: _____

Address: _____

Certified Specialist: _____

Telephone: _____

DENTIST'S REPORT

Name: _____ Address: _____ City: _____ Province: _____ Postal Code: _____ Tel: _____ Social Insurance Number: _____	Name: _____ Address: _____ City: _____ Province: _____ Postal Code: _____ Tel: _____ Social Insurance Number: _____
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Date of Service Day Mo. Yr. _____ Int. Tooth Code _____ Procedure Code _____ Tooth Surfaces _____ Laboratory Charge _____ Dentist's Fee _____ Total Charge _____	P A T I E N T	This is an accurate statement of services performed and fees charged. DATE: _____ Dentist's Signature _____ For Dentist's Use Only. For additional information re: diagnosis, procedures, or complications, and special considerations Signature of Patient (or Parent/Guardian) _____ Signature of Subscriber _____ I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents. I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.
Est. Date - Treatment Day Mo. Yr. _____ Int. Tooth Code _____ Procedure Code _____ Tooth Surfaces _____ Laboratory Charge _____ Dentist's Fee _____ Total Charge _____	P A T I E N T	I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents. I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

PART 2 - DENTIST'S SUMMARY REPORT

Description of Damage: _____

Is further treatment indicated? Yes No If "Yes" Please indicate: _____

Est. Date - Treatment Day Mo. Yr. _____	Int. Tooth Code _____ Procedure Code _____ Tooth Surfaces _____ Laboratory Charge _____ Dentist's Fee _____ Total Charge _____	Description of Damage: _____
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Describe further potential problems and indicate time frame: _____

Dentist's Signature: _____

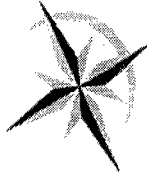
ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

Date: _____

NOTICE TO DENTIST
 Please Note: Under the terms of the policy, this report must be forwarded to the company within 90 days of the date of the accident. Your co-operation will be appreciated.

FOR PLAN ADMINISTRATOR USE ONLY

Real People. Making insurance easy.



Pearson
Dunn™
INSURANCE INC.

Introduction

Program Overview

The Insurance Program offered by Ontario Baseball Association provides Liability & Accident Coverage to its members participating in ****Sanctioned**** and **Authorized Activities**.

****Sanctioned Events**** shall mean all games, competitions or sports demonstrations run or authorized by Ontario Baseball Association including related training at sites of events, scheduled practices and banquets/award ceremonies.

The **Commercial General Liability Policy** will pay those sums that the insured becomes legally obligated to pay as compensatory damages because of bodily injury to or damage to property of others, such as spectators, passers-by, property owners and others resulting from your operations or actions. Coverage includes your legal liability for injury to participants. Most General Liability policies contain an exclusion, which excludes suits resulting from participants who are injured while participating in a sporting activity. The policy provided by Pearson Dunn Insurance Inc. & All Sport Insurance Marketing Ltd. includes injury to participants that result from your associations; members club's, or individual members negligence.

The Insurance Program also provides **Directors & Officers/Errors & Omissions Liability Coverage**, which protects the association's directors & officers, executives, employees and volunteers for consequences of their actions against suits alleging "wrongful acts". This coverage is automatically included for each member club.

The Insurance Program also provides **Sport Accident Coverage** to its members who have sustained an injury while participating in sanctioned or authorized activities. This coverage is applicable in Canada. Coverage also applies to scheduled practices or training at site of competition. This coverage is secondary to any other health care plan(s).

The Policy even includes at no additional cost, **Additional Insured's**, such as Municipalities, Government Departments, Sponsors and Owners of the Facilities in whose name you have agreed to provide insurance for their vicarious liability arising out of your operations.

SPORTS LIABILITY INSURANCE POLICY # AS1555

LIMIT: \$5,000,000/per occurrence
DEDUCTIBLE: \$500/per occurrence
EFFECTIVE: May 1, 2010 to May 1, 2011
INSURER: All Sport Insurance Marketing Ltd.
Underwritten by Aviva Insurance Company of Canada

Who is insured?

All members including Executives, Managers, Coaches, Directors, Officers, Officials, Employees, Participants & Volunteers while acting on behalf of the association. The Liability Policy will also include, as additional insured, any government departments, municipalities, sponsors and owners of facilities in whose name you have agreed to provide insurance for their vicarious liability arising out of your operations.

What are we covered for?

Commercial General Liability pays for all sums that the insured is legally obligated to pay against bodily injury or property damage caused to a third party, by an insured member. The policy will also protect any suits resulting from a participant who is injured while participating in a sanctioned sporting event.

Activities Covered?

Baseball Activities including all related training activities authorized by Ontario Baseball Association and the following;

- ✔ Organization and Operation of Sanctioned Events
- ✔ Workshops
- ✔ Conferences
- ✔ Clinics
- ✔ Camps
- ✔ Promotion of Sport
- ✔ Publication of Newsletters
- ✔ Fundraising Activities

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INSURANCE INC.

Program Overview

Highlights of Coverage

- \$5,000,000 Commercial General Liability/per occurrence
- \$5,000,000 Participant Liability
- \$5,000,000 Non-Owned Automobile Liability
- \$5,000,000 Personal Injury Liability
- \$5,000,000 Advertisers Liability
- \$5,000,000 Employers Liability
- \$5,000,000 Premises, Property and Operations Liability
- 5,000,000 Products & Completed Operations Liability/General Aggregate \$5,000,000
- Worldwide coverage = suits brought in Canada
- \$500.00 deductible
- \$5,000,000 Incidental Medical Malpractice (Non-Professionals)
- \$250,000 Tenants Legal Liability
- \$1,000 Voluntary Medical Payments (Third Party)
- Host Liquor Liability for annual awards ceremonies and wind up banquets
- Facility Owners, Sponsors, Government Departments, Municipalities as additional insured's
- \$2,000,000 Directors & Officers Wrongful Acts/Errors & Omissions Liability/per occurrence

