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|---|----------------|---|
| PRODUCER<br><br><b>CHAPPELL INSURANCE AGENCY</b><br>25807-A COX ROAD<br>PETERSBURG, VA 23803      | 1-804-733-2020 | 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<br><br><b>PLAYERS CHOICE SPORTS ASSOCIATION, INC.</b><br>P.O. BOX 566<br>DAYTON, OR 97114 |                | <b>INSURERS AFFORDING COVERAGE</b>  |
|   |                | INSURER A: <b>MT. HAWLEY INSURANCE CO.</b>  |
|   |                | INSURER B: <b>FEDERAL INSURANCE COMPANY</b>   |
|   |                | 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        | <b>GENERAL LIABILITY</b>  | MPE 0005240   | 01/01/09                         | 01/01/10                          | EACH OCCURRENCE                     | \$ 2,000,000 |
|          | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY  |               |                                  |                                   | FIRE DAMAGE(any one fire)           | \$ 300,000   |
|          | <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR  |               |                                  |                                   | MED EXP (any one person)            | \$ EXCLUDED  |
|          | <input type="checkbox"/> _____  |               |                                  |                                   | GENERAL AGGREGATE                   | \$ 2,000,000 |
|          | <input checked="" type="checkbox"/> PLL-\$2,000,000   |               |                                  |                                   | PERSONAL ADV INJURY                 | \$ 2,000,000 |
|          | GEN'L AGGREGATE LIMIT APPLIES:<br><input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC |               |                                  |                                   | PRODUCTS - COMP/OP AGG              | \$ 2,000,000 |
| B        | <b>OTHER</b>  | 99062235      | 01/01/09                         | 01/01/10                          | \$100,000 LIMIT<br>\$250 Deductible |              |
|          | SECONDARY PARTICIPANT ACCIDENT  |               |                                  |                                   |                                     |              |
|          | <b>EXCESS LIABILITY</b>   |               |                                  |                                   | EACH OCCURRENCE                     | \$           |
|          | <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR   |               |                                  |                                   | 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 2/27/2009.**

|  |   |   |
|--|---|---|
| <b>CERTIFICATE HOLDER</b>  | <b>ADDITIONAL INSURED; INSURER LETTER</b> _____ | <b>CANCELLATION</b>   |
| <b>FOWLerville JR. BASEBALL ASSN (4)Teams</b><br>PO BOX 418<br>FOWLerville, MI 48836 |   | 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. |
| CERTIFICATE #: BB-9-539  |   | AUTHORIZED REPRESENTATIVE<br>   |



Policy Number:  
 \_\_\_\_\_ 9906-2235 \_\_\_\_\_

**FOWLerville JR. BASEBALL ASSN**  
**BB-9 - 539**

1. Please fully complete this form
  2. Attach Itemized bills
  3. Mail to ----->
- E-mail: **CHUBB@hsri.com**

HSR Plaza II  
 4100 Medical Parkway Carrollton, Texas 75007  
 Phone: (972) 512 - 5600 Fax: (972) 512 - 5820  
 866-523-3199

|   |              |                  |
|---|--------------|------------------|
| FOR HSR USE ONLY: Claim Company # _____ | Plan # _____ | Location # _____ |
|---|--------------|------------------|

### PART I - POLICYHOLDER'S REPORT

|  |  |  |  |           |
|--|--|--|--|-----------|
| 1. Claimant's Name (Injured Person)  | 2. Social Security Number<br>- -   | 3. Gender<br>_M _F   | 4. Birthday<br>___/___/___               | 5. Email  |
| 6. Address of injured person and best contact phone number (including area code)                         |  |  |  |           |
| 7. If applicable, Parent's Name, Address, and best contact phone number (including area code)            |  |  |  |           |
| 8. Date and time of accident   | 9. Place where accident occurred   | 10. Was insured a participant, staff member, guest or volunteer? |  |           |
| For Dental Claims only   | 11. Indicate which teeth were involved in the accident   |  |  |           |
|  | 12. Describe condition of teeth prior to accident: <input type="checkbox"/> Whole, sound and natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial |  |  |           |
| 13. Nature of Injury (indicate part of body injured - such as broken arm, sprained ankle, etc)           |  |  |  |           |
| 14. 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 programmed, sponsored & supervised, or sanctioned activity?                     |  |  |  | Yes    No |
| B. On activity Premises?   |  |  |  | Yes    No |
| C. While on the job (if applicable)?   |  |  |  | Yes    No |
| D. 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 |
| 16. Name of event or activity  |  |  | 17. Name and Title of Supervisor         |           |
| 18. Name of policyholder   |  | 19. Address of Policyholder (address, city, state, zip)          |  |           |
| 20. Signature of policyholder representative   |  |  | 21. Title of Policyholder Representative |           |
|  |  |  | 22. Date                                 |           |

### PART II - OTHER INSURANCE STATEMENT

Do you/Spouse/Parent have medical/health care or is the Claimant enrolled as an individual, employee, or dependent member of a Health Maintenance Organization (HMO) or similiar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree?     Yes     No

If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Claimant's primary employee name, address, and phone number \_\_\_\_\_

Mother's primary employee name, address, and phone number \_\_\_\_\_

Father's primary employee name, address, and phone number \_\_\_\_\_

**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, consultation, 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 \_\_\_\_\_