

Southeast Valley Babe Ruth

Date: _____ Phone: _____

Players Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip: _____

Fathers Name: _____ Employer: _____ Phone: _____

Mothers Name: _____ Employer: _____ Phone: _____

Prior Team in Babe Ruth (if applicable): _____

PRIMARY INSURANCE

Name of Insurance Company, Player is covered under: _____

Policy# _____

This policy covers all players, coaches and managers, on a league-registered team, including anyone who becomes eligible during the term of coverage. Coverage is provided while participating in a regularly scheduled and supervised practice and play of Babe Ruth Baseball and related covered scheduled activities. The medical expense benefit of this plan is an "excess" type benefit that picks up where other coverage leaves off. If you have other individual, blanket or group coverage which provides benefits or services for, or by reason of medical or dental care or treatment, then this plan will pay only the medical expenses not provided or reimbursable under other coverage. If the parent/guardian has coverage with pre-paid medical plans: such as CIGNA or Intergruop, etc, the injured player must be taken to the pre-paid medical facilities for treatment. All claims against this plan must be filed within 60 days of the accident. A league accident report should be completed and turned into league president for verification immediately.

There will be either a team deductible or a player deductible on the insurance carried by SOUTHEAST VALLEY BABE RUTH.

I understand that all teams registered in this league operate as a separate entity and all financial obligations (uniforms,tournaments and equipment) is the responsibility of my specific team and not Babe Ruth Baseball.

Parent/Guardian _____

Date: _____

EMERGENCY MEDICAL RELEASE

I/we the parents/guardians of _____, give our permission for any emergency medical treatment necessary either on the practice field or on the game field. I/we authorize any hospital and/or physician to perform emergency medical treatment for any injuries.

Parent/Guardian _____

Date: _____