

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
1/10/2012

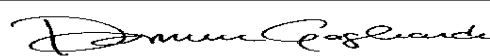
PRODUCER Gagliardi Insurance Services, Inc. 284 Digital Drive Morgan Hill, CA 95037	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
	INSURERS AFFORDING COVERAGE	NAIC #
INSURED Youth Baseball of Rowlett, Inc. P.O. Box 776 Rockwall, TX 75087	INSURER A: New York Marine & General Insurance Co	20281
	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, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A		GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Abuse & Molestation	PK201200000419	2/16/2012	2/16/2013	EACH OCCURRENCE \$ 1,000,000
		DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000				
		MED EXP (Any one person) \$ -0-				
		PERSONAL & ADV INJURY \$ 1,000,000				
		GENERAL AGGREGATE \$ 2,000,000				
		PRODUCTS - COMP/OP AGG \$ 2,000,000				
		Participant Legal Liab \$ 1,000,000				
A		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	PK201200000419	2/16/2012	2/16/2013	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
		BODILY INJURY (Per person) \$				
		BODILY INJURY (Per accident) \$				
		PROPERTY DAMAGE (Per accident) \$				
		AUTO ONLY - EA ACCIDENT \$				
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				OTHER THAN AUTO ONLY: EA ACC \$
						AGG \$
		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$				EACH OCCURRENCE \$
		AGGREGATE \$				
		\$				
		\$				
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
		E.L. EACH ACCIDENT \$				
		E.L. DISEASE - EA EMPLOYEE \$				
		E.L. DISEASE - POLICY LIMIT \$				
B		OTHER Youth BB Medical \$250 Ded	9907-0913	2/16/2012	2/16/2013	AD&D/Dental 10,000/3,000 Limit 100,000

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

CERTIFICATE HOLDER Youth Baseball of Rowlett, Inc. P.O.Box 776 Rockwall, TX 75087-	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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		AGGREGATE \$				
		\$				
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		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
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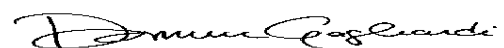
CERTIFICATE HOLDER

USSSA
259 Plantation Point
Natchitoches, LA 71457-

CANCELLATION

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AUTHORIZED REPRESENTATIVE



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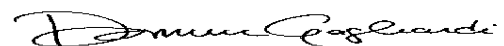
CERTIFICATE HOLDER

Super Series Baseball
3449 East Kael Street
Mesa, AZ 85213-

CANCELLATION

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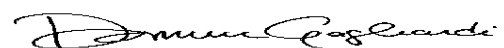
CERTIFICATE HOLDER

PONY Baseball
 P.O.Box 225
 Washington, PA 15301-

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.

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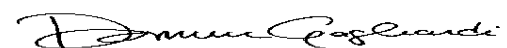
CERTIFICATE HOLDER

City of Rowlett
4000 Main Street
Rowlett, TX 75088-

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		E.L. DISEASE - POLICY LIMIT \$				
B		OTHER Youth BB Medical \$250 Ded	9907-0913	2/16/2012	2/16/2013	AD&D/Dental 10,000/3,000 Limit 100,000

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

THE CERTIFICATE HOLDER IS INCLUDED AS AN ADDITIONAL INSURED, BUT ONLY AS RESPECTS TO CLAIMS ARISING OUT OF NEGLIGENCE OF THE NAMED INSURED.

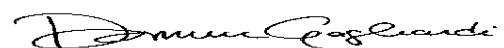
CERTIFICATE HOLDER

Texas Tournament Baseball
512 N. Hampton #216
De Soto, TX 75115-

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



ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
1/10/2012

PRODUCER Gagliardi Insurance Services, Inc. 284 Digital Drive Morgan Hill, CA 95037		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.	
		INSURERS AFFORDING COVERAGE	NAIC #
INSURED Youth Baseball of Rowlett, Inc. P.O. Box 776 Rockwall, TX 75087		INSURER A: New York Marine & General Insurance Co	
		INSURER B: Federal Insurance Company	20281
		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, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Abuse & Molestation	PK201200000419	2/16/2012	2/16/2013	EACH OCCURRENCE	\$ 1,000,000
		DAMAGE TO RENTED PREMISES (Ea occurrence)				\$ 300,000	
		MED EXP (Any one person)				\$ -0-	
		PERSONAL & ADV INJURY				\$ 1,000,000	
		GENERAL AGGREGATE				\$ 2,000,000	
		PRODUCTS - COMP/OP AGG				\$ 2,000,000	
		Participant Legal Liab				\$ 1,000,000	
A		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	PK201200000419	2/16/2012	2/16/2013	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
		BODILY INJURY (Per person)				\$	
		BODILY INJURY (Per accident)				\$	
		PROPERTY DAMAGE (Per accident)				\$	
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT	\$
		OTHER THAN AUTO ONLY: EA ACC				\$	
		AGG				\$	
		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$				EACH OCCURRENCE	\$
		AGGREGATE				\$	
						\$	
						\$	
						\$	
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS	OTH-ER
		E.L. EACH ACCIDENT				\$	
		E.L. DISEASE - EA EMPLOYEE				\$	
B		OTHER Youth BB Medical \$250 Ded	9907-0913	2/16/2012	2/16/2013	AD&D/Dental 10,000/3,000	Limit 100,000

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

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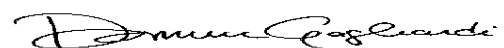
CERTIFICATE HOLDER

Northeast Classic Baseball League
 3526 Lakeview Parkway #141
 Rowlett, TX 75088-

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



ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
1/10/2012

PRODUCER Gagliardi Insurance Services, Inc. 284 Digital Drive Morgan Hill, CA 95037	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 Youth Baseball of Rowlett, Inc. P.O. Box 776 Rockwall, TX 75087	INSURERS AFFORDING COVERAGE INSURER A: Great American Insurance Company INSURER B: New York Marine & General Insurance Co INSURER C: INSURER D: INSURER E:	NAIC #

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, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS												
		GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR <hr/> GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$												
		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$												
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$												
		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$												
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%;">WC STATUTORY LIMITS</th> <th style="width:10%;">OTHER</th> <th style="width:80%;"></th> </tr> <tr> <td></td> <td></td> <td>E.L. EACH ACCIDENT \$</td> </tr> <tr> <td></td> <td></td> <td>E.L. DISEASE - EA EMPLOYEE \$</td> </tr> <tr> <td></td> <td></td> <td>E.L. DISEASE - POLICY LIMIT \$</td> </tr> </table>	WC STATUTORY LIMITS	OTHER				E.L. EACH ACCIDENT \$			E.L. DISEASE - EA EMPLOYEE \$			E.L. DISEASE - POLICY LIMIT \$
WC STATUTORY LIMITS	OTHER																	
		E.L. EACH ACCIDENT \$																
		E.L. DISEASE - EA EMPLOYEE \$																
		E.L. DISEASE - POLICY LIMIT \$																
A		Director & Officers Baseball	EPP9712262	2/16/2012	2/16/2013	Deductible 500 Limit 1,000,000												
B		Fidelity Bond Baseball	CR2012SPT00010	2/16/2012	2/16/2013	Deductible 250 Limit 35,000												

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

CERTIFICATE HOLDER Youth Baseball of Rowlett, Inc. P.O.Box 776 Rockwall, TX 75087-	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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Please print or type. Incomplete forms will be returned.
 SEND COMPLETED FORM & BILLS TO:

Underwritten by:



NAHGA
Claim
Services

NAHGA Claim Services
 PO Box 189
 Bridgton, Maine 04009
 (800) 952-4320
 (207) 647-4569 Fax

IMPORTANT NOTICE:

This insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

If this form is not completed in FULL, this claim can not be processed and will be returned.

PART 1: POLICYHOLDER & INSURED			
(1) Promoter/Team/League Name Youth Baseball of Rowlett, Inc.		(2) Policy Number/Class Code 9907-0913 Option 1C	
(3) Claimant - Last Name, First Name		(4) Claimant Social Security Number	
(5) Mailing Address where Insurance Info/Requests should be mailed		(6) City, State, Zip	
(7) Birthdate	(8) Male <input type="checkbox"/> Female <input type="checkbox"/>	(9) Phone	(10) Email
INJURY - Please Complete this Section to report an injury			
(11) Date of Injury	(12) Time & Address where occurred?	(13) Part of body injured	
(14) How did injury occur (description of incident)?		(15) Date of first medical treatment	
(16) Type of Sport (if applicable)		(17) Sport Designation: Practice <input type="checkbox"/> Game <input type="checkbox"/> Event <input type="checkbox"/> Other <input type="checkbox"/> _____	
(18) Action Taken: <input type="checkbox"/> Released to Parent <input type="checkbox"/> Ambulance Transport <input type="checkbox"/> Referred to Hospital/Clinic <input type="checkbox"/> Own Accord (Adult) <input type="checkbox"/> Other _____			
(19) Was the claimant supervised when injured? Yes <input type="checkbox"/> No <input type="checkbox"/>		(20) Was injury during travel to or from scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/>	
(21) Signature of Policyholder: _____		Date _____	

PART 2: PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)			
(1) Father/Guardian Name		(9) Mother/Guardian Name	
(2) Home Address (Street, City, State, Zip)		(10) Home Address (Street, City, State, Zip)	
(3) Telephone	(4) Email	(11) Telephone	(12) Email
(5) Employer		(13) Employer	
(6) Father's Employer Address (Street, City, State, Zip)		(14) Mother's Employer Address (Street, City, State, Zip)	
(7) Business Phone		(15) Business Phone	
(8) Employer Medical Insurance Policy		(16) Employer Medical Insurance Policy	
(8a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>		(16a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>	

PART 3: INSURANCE VERIFICATION	
Is Claimant covered by any other insurance policy (other than this policy), either as a dependent, group, individual, automobile medical or liability? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please list name of insurance carrier: _____	
Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.	

PART 4: AUTHORIZATION	
I hereby authorize any hospital, policyholder, physician, employer, or other person who has attended or examined the Claimant to disclose when requested to do so, any information to NAHGA CLAIMS or POLICYHOLDER with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A copy of this authorization shall be considered as valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.	
X	
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) _____	Date _____
AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.	
X	
Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) _____	Date _____
<i>Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.</i>	

GAGLIARDI INSURANCE SERVICES, INC.

284 Digital Drive, Morgan Hill, CA 95037 408-414-8100 Fax 408-414-8199

IMPORTANT INSTRUCTIONS HOW TO FILE YOUR MEDICAL CLAIM

You have been provided with claim forms that are pre-filled with some of the important information that is needed to process your claim efficiently. Please use only this form.

1. Part 1: Must be filled out completely.
2. Part 2: Must be completed if the claimant is a minor and must be fully filled out.
3. Part 3: Must be filled out if there is Primary Insurance - If there is no Primary Insurance- **“NO” MUST BE CHECKED OFF AND SIGNED TO AVOID ANY DELAY IN PAYMENT** .
4. Include all itemized bills for related medical expenses being claimed. These bills must show the patients name, condition being treated (diagnosis), type of treatment received, date the expense(s) was/were incurred.
5. If you have already paid the bills please include a receipt or proof of payment.
6. A deductible will apply to each claim.
7. A League Representative, Promoter or Insurance Coordinator **must** sign Claim Form in line 21.

NOTE:

This coverage is in excess of all other group medical coverage. Please complete, in full, the attached **Other Insurance Inquiry (Part 3)** and provide copies of the other insurance's **Explanation of Benefits** for each corresponding **Itemized Bill**. If there is no other insurance please specify this in that area (check “No”). Failure to provide this form, completed in its entirety, will delay claim processing. (You have 15 days from the date of the event to submit a claim form to NAHGA)

Mail **FULLY COMPLETED** Claim Form to:

Nahga Claim Services
PO Box 189
Bridgton, Maine 04009
(800) 952-4320
(207) 647-4569 Fax

For questions, inquiries and/or status of your claim, call (800) 952-4320