M E M O

TO: TOURNAMENT DIRECTOR

FROM: CENTRAL CALIFORNIA ASA

CC: TOURNAMENT UIC

RE: TOURNAMENT FEES AND DIRECTORS RESPONSIBILITIES FOR TOURNAMENTS

You are scheduled to host a CCASA sanction tournament. CCASA approved ASA tournaments require some type of fees payable to this office. Listed on the tournament report form are the fees for your event. If your tournament has an UIC or a CCASA ASA Representative assigned (usually JO Tournaments), they are tasked to collect the fees Saturday and forms Sunday. Please make arrangements to accomplish this task before the end of the event. **Do Not send this material directly to this office.**

If you have no UIC/CCASA REP (usually adult tournaments) then the tournament director is responsible for collecting fees and sending all fees and forms to the CCASA Office.

NOTE: Fourteen (14) working days before the event**, contact your UIC** as to where you stand on the number of fields and sites along with game times. **Seven (7) days before the event, you must contact the UIC to finalize the tournament operations and special rules**. The UIC will handle all rule protests as listed in the ASA code or written modification by the tournament director. UIC and ASA Representative, if available, will be members of your protest committee. Assoc. policy is the team entry cutoff point shall be a **Monday** draw prior to the weekend event. **Exception:** With the concurrence of the UIC an extension to Wednesday is permissible. **Remember there are other events going on and umpire resources are limited!!!**

UIC and umpire fee chart can be found on www.centralcalasa.com for your use and information. Tournament directors comment on improving or changing the tournament procedure is requested. These will be passed on to the Tournament Director Committee for action.

Tournament insurance is required! See enclosed forms. Please contact CCASA Secretary Jessica Ralls to purchase tournament insurance NO LATER THAN NOON 3 days prior to the start of your tournament. jessica.ralls@centralcalasa.com

Any incidents should be called into the Association Office on a daily basis to include any injuries, physical acts or protest. Complete Accident & Incident Claim reports (included in this packet) & mail/email/or fax to Assoc. Office within two days.
Assoc. phone number: 805-466-8505, Assoc. fax number: 805-462-1026
Email: jessica.ralls@centralcalasa.com

Please note the "NEW" umpire assignment procedures and possible addition lodging cost that may pertain to your tournament (*page 2*). Because of increased tournament events, the Assoc. is trying to use local league umpires and the County UIC based upon the type and classification of event and its location. Championship Play events will have priority over all other events!

UMPIRE SELECTION AND GUIDELINES FOR Adult or Youth Events

I. Sanction Youth

(1) UIC assignment:	Local UIC will be given priority for county event. Touching county UIC/Assignor next priority.
(2) Umpires:	*Class A youth/all adult FP/SP, priority to umpires in the county, then touching counties less then 45 minute drive. *Class B youth, priority to umpires from the local league, then other umpires within the county to touching counties less then 45 minute drive. *Class C youth, priority to umpires from the local league, then other umpire's within the county to touching counties less then 45 minute drive.
***Exception**:	If the tournament has 30 or more teams, lodging for four to six out of area umpires (3 rooms) one/two nights at the expense of the tournament director if starting Friday, plus out of town UIC room. **(Note: If needed)**

II. CHAMPIONSHP PLAY

Regional/Territory/Assoc/ /Qualifiers, hosted by the Assoc., City Recreation or Independent organizations.

(1) UIC assignment:	Selection by Association UIC.
(2) Umpires:	Best umpires from host county and touching counties.
Exception:	Tournament with 28 or more teams, lodging for four to six Out of area umpires (3 rooms) one night at the expense of the tournament director, plus out of town UIC room. **(Note: If needed)**

CENTRAL CALIFORNIA AMATEUR SOFTBALL ASSOCIATION
ASA / USA SOFTBALL
TOURNAMENT REPORT FORM / INVOICE

Tournament Date ______ Fast ____ Slow ____ Youth (ages) ____ - ____ Adult ____ Type ____

Tournament Director ______________ Phone # ______________

Tournament UIC ______________ Phone # ______________

A: UIC & UMPIRE FEES (See Fee Chart)

Total number of Games		(does not include "If" game(s))				
UIC Fee: No. of Time Slots		X Slot Rate	? x 25	=	Total	$
AUIC Fee: No. of Time Slots		X Slot Rate	? x 20	=	Total	$
WUIC Fee: No. of Days		X One Game Fee	? x 32	=	Total	$
Umpire Fees: Number of Games @ 1 Ump X Rate			?? x 48	=	Total	$
Umpire Fees: Number of Games @ 2 Ump X Rate			?? x 64	=	Total	$
Umpire Fees: Number of Games @ 3 Ump X Rate			?? x 96	=	Total	$
Umpire Fees: Number of **8U** Games @ 1 Ump X Rate			?? x 47	=	Total	$
Umpire Fees: Number of **8U** Games @ 2 Ump X Rate			?? x 62	=	Total	$

Umpire Fees are due to the UIC Prior to the afternoon games — **Total Ump Fees $**

B: ASSOCIATION SANCTION FEES

$25.00	Per Youth Age Group X # of Age Groups	? X 25.00	=	$
$10.00	Trny ASA Fee (if Applicable) X # Teams	? X 10.00	=	$
$3.00	Assignment Fee X # of Umpires	? X 3.00	=	$

Association Fees are due to the UIC Prior to the afternoon games — **Total Association Fees $**

Make Check Payable to CCASA — **GRAND TOTAL (B) $**

Instructions for completing (Youth Sanctioned Tournaments)

1. **Everything above Section A should be complete, if not, please complete it.**
2. **Section A** is for your convienience to figure out fees for you, your UICs if any and the umpires. Use it or your own notes.
3. **Section B** is the area of importance. These are fees due to be paid from the "Tournament" to the Association office, and you are responsible for collecting them, finishing the paperwork and routing everything to the office immediately after the tournament. Follow these directions:
   1) Total the Umpire Assigning Fees
   2) Total the Sanction Fees per Age Group
   3) Total the Trny ASA Fee per Team (if using service)

Note: The $3.00 Assigning fees & $25 per age group apply to ALL Youth Sanctioned Tournaments (A, B & C).

   5) Finally total section B and put the total where it asks for Total Association Fees.
4. **Enter the grand total and send your payment and this form to the address below so it is received by the CCASA Office within 10 business days of the tournament:**

CENTRAL CALIFORNIA ASA
PO Box 820
Paso Robles, CA 93447

ACCIDENT REPORT

Central California ASA

Phone: Tom Dowd 559-281-1622

FACILITY___________________________ **LOCATION**____________________**TYPE OF EVENT** __________

DATE OF INCIDENT______________________ **TIME**___________ **TEAM NAME:** _______________________

INJURED NAME _________________________________ **AGE**______ **PHONE**__________________________

ADDRESS OF INJURED ____

WHAT WAS INJURED INDIVIDUAL DOING WHEN HURT?_______________________________________

____

____

HOW WAS INJURED INDIVIDUAL HURT?____

____

____

EXTENT OF INJURY (specific description of incident including area of the body affected)

____

____

ACTION TAKEN BY TRNY DIRECTOR ____

____

HOW AND WHERE WAS INJURED INDIVIDUAL TAKEN AFTER ACCIDENT_______________________

____

____

IF BY AMBULANCE, PERSON REQUESTING IT: NAME____

ADDRESS____ **PHONE**____________________________________

PARENT NAME___________________________________ **PHONE** ___________________________________

ADDRESS____ **CITY**______________________**ZIP**___________

WITNESS NAME	**ADDRESS**	**PHONE**
___________________	____	______________________________
___________________	____	______________________________

Trny Directors Signature____ **Date**______________________

Date Received at ASA______________________________ **Rec'd By** ____________________________________

IN THE EVENT OF A SERIOUS ACCIDENT REQUIRING MEDICAL ATTENTION, CONTACT TOM DOWD at 559-281-1622 or Assoc Office at 805-466-8505. Mail form to PO Box 625, Clovis, CA 93613-0625

Please give one copy to Tom Dowd, one copy to site/city contact and one copy to the Trny Director

Complete & Return this Form to:

Medical/Dental Accident Claim Form

BOLLINGER SPORTS & LEISURE

P.O. Box 390 Short Hills, NJ 07078

Individual Registration

90/10 co-insurance

52-week benefit period

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN (Required)

1. **NAME:** (first) ______________________ (last)______________________________
2. **ADDRESS**: ______________________ (city) ______________ (state) _____ (zip code)______
3. **TELEPHONE #:**____
4. **BIRTHDATE:** ___/___/___ **SEX:** ☐ Male ☐ Female **SS#:**________________
5. **CLAIMANT IS A:** ☐ **YOUTH** ☐ **COACH/MANAGER** ☐ **OTHER:**________________
6. **NAME OF LEAGUE AND NAME OF TEAM:**______________________________
7. **TOURN NAME:**____________ **TYPE:**________ **DIRECTOR NAME & #:**________________
8. **ASA ID CARD #:** ________________ **(Include copy of card)** **FASTPITCH** ☐ **SLOWPITCH** ☐
9. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** ________ ☐ am ☐ pm
10. **BODY PART INJURED:**____
11. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Other____________
12. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**______________________________

____

13. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**______________________________

SECTION II VERIFICATION TEAM/LEAGUE OFFICIAL SIGNATURE (Required) Policy #:4102AH220317

I CERTIFY THAT THE ABOVE NAMED CLAIMANT IS AN INSURED MEMBER OF THE TEAM NAMED ABOVE AND THAT THE INJURY OCCURRED DURING OFFICIAL TEAM ACTIVITIES AS STATED.

NAME OF TEAM/LEAGUE OFFICIAL: ______________________ TITLE:______________________

SIGNATURE OF TEAM/LEAGUE OFFICIAL: ______________________ DATE: ____________ PHONE: ____________

SECTION III VERIFICATION ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner Signature (Required)

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS A REGISTERED MEMBER OF THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF ASA STATE OR METRO COMMISSIONER:______________________ TITLE: ______________________

SIGNATURE OF ASA STATE OR METRO COMMISSIONER:______________________ DATE: ____________ PHONE: ________

Check deductible option selected for player/clmt at the time of registration: $125_____ $250_____ $500_____

Was this injury a result of an ASA event? [ ] yes [ ] no

If no, indicate name of Organization that held event:

SECTION IV STATEMENT OF OTHER INSURANCE (Required)

Father/Claimant

NAME:____________________

ADDRESS:____________________

CITY:____________________

STATE:__________ ZIP:__________

PHONE:____________________

EMPLOYER:____________________

PHONE:____________________

EMAIL:____________________

SELF EMPLOYED ☐ UNEMPLOYED ☐

Mother/Claimant

NAME:____________________

ADDRESS:____________________

CITY:____________________

STATE:__________ ZIP:__________

PHONE:____________________

EMPLOYER:____________________

PHONE:____________________

EMAIL:____________________

SELF EMPLOYED ☐ UNEMPLOYED ☐

If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? ☐ YES ☐ NO
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? ☐ YES ☐ NO

INSURED NAME:_______________ ID#:__________ INSURED GRP#/NAME:_______________

INSURANCE COMPANY NAME:______________________________

ADDRESS:______________________________

CITY:_______________ STATE:_______________ ZIP:_______________

PHONE:______________________________

****ARE YOU INSURED WITH ANY OTHER SOFTBALL ORGANIZATION. ☐ YES ☐ NO**
IF YES, INDICATE THE ORGANIZATION, CONTACT PERSON'S NAME & PHONE NUMBER:

____

***Please include copy of insurance card (both sides)**

Note: **IF YOUR SON OR DAUGHTER HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM A PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY:** ______________________________

SECTION V ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING INDICATES PAYMENT MADE BY YOU.

SECTION VI STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required):_________________________ DATE:____________

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by RPS Bollinger or its representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (required):_________________________ DATE:____________

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. If you receive Government or State Aid Insurance (Medicaid, Medicare, etc) this insurance may be Primary; please contact RPS Bollinger for coverage information.

   - Payment under this policy will be made according to **usual and customary guidelines.** This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **90** days up to **1 year** from date of injury to submit claim form.
   For claims to be eligible for coverage, you must seek medical attention within **60 days** from date of injury.

   Benefit Period: This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**
   a) **Only submit the Claim Form to RPS Bollinger**
   b) Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to RPS Bollinger
   c) **Itemized bills are required**: You or your providers must submit itemized bills with your primary insurance explanation of benefits (if applicable); balance due bills or notices **do not** provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

   - **CMS-1500** is the standard form used by Providers to show the medical treatments and charges made for each service.
   - **UB-04** is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy. Please have your provider submit an ADA dental claim form with the explanation of benefits (if applicable).

For further information contact:

RPS Bollinger, Sports Claims Department
P.O. Box 390 Short Hills, NJ 07078
(P) 866.267.0093
(F) 973.921.2876
SportsClaims@Bollinger.com

www.Bollinger.com **www.BollingerASA.com**

Fraud Statements

GENERAL: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.
ALASKA: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
DISTRICT OF COLUMBIA RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.
LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.
NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.
PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.
RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Complete & Return this Form to:

Medical/Dental Accident Claim Form

PROGRAMS

BOLLINGER SPORTS & LEISURE

P.O. Box 390 Short Hills, NJ 07078

THE NATIONAL GOVERNING BODY OF SOFTBALL

UMPIRE

$250 Deductible 90/10 co-insurance 52-week benefit period

SECTION I — TO BE COMPLETED BY CLAIMANT (Required)

1. **NAME:** (first)________________ (last)________________
2. **ADDRESS:**________________ (city)________ (state)______ (zip code)________
3. **TELEPHONE #:**________________
4. **BIRTHDATE:** ___/___/___ **SEX:** ☐ Male ☐ Female **SS#:**________________
5. **FASTPITCH** ☐ **SLOWPITCH** ☐
6. **YOUTH** ☐ **ADULT** ☐
7. **ASA EVENT? YES** ☐ **NO** ☐ **IF NO, PLEASE SPECIFY:**________________
8. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** ________ ☐ am ☐ pm
9. **BODY PART INJURED:**________________
10. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Other________
11. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**________________

____

____

12. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**________________

PLEASE NOTE: THIS FORM CANNOT BE SUBMITTED WITHOUT THE REQUIRED SIGNATURE

SECTION II VERIFICATION (Must be signed by ASA State or Metro Commissioner or Official Designated by State or Metro Commissioner) Policy#:4102AH222098

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS A REGISTERED UMPIRE WITH THE AMATEUR SOFTBALL ASSOCIATION OF AMERICA FOR THE CURRENT SEASON.

NAME OF ASA STATE/METRO COMMISSIONER: ________________ TITLE: ____________

SIGNATURE OF ASA STATE/METRO COMMISSIONER: ________________ DATE: ____________

SECTION III STATEMENT OF OTHER INSURANCE (Required)

Claimant

NAME:____________________

ADDRESS:____________________

CITY: ____________________

STATE:__________ ZIP:__________

PHONE:____________________

EMPLOYER NAME:____________________

EMPLOYER PHONE:____________________

SELF EMPLOYED ☐ UNEMPLOYED ☐

EMAIL:____________________

If you are employed but have no insurance, you must include a letter of verification from your employer on their letterhead that no insurance is provided to you through your workplace.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? ☐ YES ☐ NO
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? ☐ YES ☐ NO

INSURED NAME:__________ ID#: __________INSURED GROUP# /NAME: __________

INSURANCE COMPANY NAME: ____________________

ADDRESS: ____________________

CITY: __________STATE: __________ZIP: __________

PHONE: ____________________

SECTION IV AUTHORIZATION REGARDING PAYMENT OF BENEFITS

ALL CLAIM BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED, UNLESS BILLING PROVIDED INDICATES PAYMENT MADE BY YOU.

SECTION V STATEMENT OF CERTIFICATION and AUTHORIZATION TO RELEASE INFORMATION (Required)

1. I CERTIFY that the above information given by me in support of this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (required):____________________DATE:__________

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by RPS Bollinger or their representatives, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT (required):____________________ DATE:__________

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. If you receive Government or State Aid Insurance (Medicaid, Medicare, etc) this insurance may be Primary; please contact RPS Bollinger for coverage information.

   - Payment under this policy will be made according to **usual and customary guidelines.** This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the “usual and customary” fee for that service in your area.

2. **Claim Guidelines:** You have **90** days up to **1 year** from date of injury to submit claim form.
   For claims to be eligible for coverage, you must seek medical attention within **60 days** from date of injury.

   Benefit Period: This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**
   a) **Only submit the Claim Form to RPS Bollinger**
   b) Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to RPS Bollinger
   c) **Itemized bills are required**: You or your providers must submit itemized bills with your primary insurance explanation of benefits (if applicable); balance due bills or notices **do not** provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

   - **CMS-1500** is the standard form used by Providers to show the medical treatments and charges made for each service.
   - **UB-04** is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental bills:** All dental bills must be submitted through your primary insurance’s **medical and dental plans** first before making a claim for dental treatment under this policy. Please have your provider submit an ADA dental claim form with the explanation of benefits (if applicable).

For further information contact:

RPS Bollinger, Sports Claims Department
P.O. Box 390 Short Hills, NJ 07078
(P) 866.267.0093
(F) 973.921.2876
SportsClaims@Bollinger.com

PROGRAMS
BOLLINGER SPORTS & LEISURE

www.Bollinger.com www.BollingerASA.com

Fraud Statements

GENERAL: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
DISTRICT OF COLUMBIA RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.
LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.
NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA [illegible].
NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: [illegible] by submitting an application, or [illegible] by filing a claim containing a false statement as to any material fact, may be violating state law.
PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.
RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Central California ASA - Individual Payment Record

Name of Tournament:___________________________________ City:_____________________________ Age Groups:________________

Trny Dates:___________________________ Person Receiving Advance:_______________________________ Amount: $_________________

	Name (PRINT NEATLY)	# of Games	x Game Rate	= Total Paid	Date Paid	Signature for payment received
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Grand Total Paid Out: _____________________________ Total $ Amount to be returned (if any): ___________________________________

Remarks: ____

____

Revised: January 2015

TOURNAMENT DIRECTORS RULES
SANCTIONED YOUTH AND ADULT TOURNAMENTS

CENTRAL CALIFORNIA SOFTBALL ASSOCIATION takes pride in providing softball events to its members. As the director of an ASA sanctioned event, the Association relies on the tournament director to follow ASA rules and code when conducting a sanctioned softball tournament. The following rules have been established by CCASA for the benefit of all. These rules are separate from Assoc., Regional and National Championship play.

Sanctioned tournaments are local events that do not qualify as ASA Championship play. Local leagues, CCASA member teams, and CCASA member cities may be sanctioned to organize an event.

TOURNAMENT DIRECTOR RESPONSIBILITIES – Non-Championship Play.

General Information

The following apply to all tournaments sanctioned by CCASA.

1. The following information is required to be included on your tournament flyer:
   - Name, phone number, mailing address, e-mail address, and fax of the Tournament Director or designee.
   - Type of event (double elimination, pool play to single elimination, etc.)
   - Division, classification
   - Game guarantee
   - Registration deadline
   - Starting time of event along with name and location of the fields being used for the event.
   - Individual and team prizes offered and the statement that the award package will be based on the number of entries per age division.
   - Statement that after the tournament draw has been completed, teams will forfeit entry fee if they withdraw.
   - Date when teams will be notified of first game time.
   - Maximum number of teams if applicable.
   - Cost of the event.
   - Name of the event (if the event is actually named).
   - Amount of parking and/or gate fee to be charged.

2. Only teams currently registered ASA are eligible to participate. Teams may not play in a lower classification.

3. Do not accept more teams than can be accommodated by the available facilities.

4. All CCASA sanctioned events shall be played under the CCASA "Code of Conduct". It is the duty of the Tournament Director to administer the code and report any violations to CCASA officials for review and possible disciplinary action. CCASA has the authority to review and impose penalties as outlined in the Code of Conduct.

5. There are four recognized tournament formats ***<u>drop dead is NOT allowed</u>***:

   Double Elimination: Teams are blind drawn into an ASA approved double elimination bracket
   Three Game Elimination: Teams are blind drawn into an ASA approved 3 game elimination bracket
   Round Robin: All teams play each other. Best record wins
   Pool play to Single Elimination: Blind pool draw with pool play seeding teams into a single elimination bracket

6. It is the responsibility of the Tournament Director to provide the following to the CCASA office, and will be collected by the designated CCASA representative at the conclusion of the event:

   - List of teams and the order of finish.
   - Tournament sanction fees as subscribed by CCASA policy. See enclosures for adult and youth event fees.

7. Have a protest committee of at least three people (Tournament Director, U.I.C., Player Rep). If a player or team is removed under disqualification procedures, the Tournament Director must hold a hearing on the player or team before the next game. You must give the team or player due process under the ASA code. See the ASA Competition Procedures Code, Article 505 Disqualification in the ASA guide for procedures.

8. When using more than one facility, (i.e. two complexes where travel is required); communications are required between the sites. Tournament Director or assistant MUST be on site at all times.

9. Umpires must be ASA registered. It is the responsibility of the Tournament Director to provide lodging for umpires if they are traveling from a significant distance. See Association Tournament Policy.

10. Fields must meet ASA requirements for safety. It is the responsibility of the umpire to decide if a field is safe for play.

11. Minimum maintenance standards: All fields must be re-lined after each game and infield must be watered after every other game.

12. The tournament schedule and tournament rules must be posted at all sites.

13. The following information should be included in the team packet to be distributed at check in.
    - Tournament rules shall state the following: “In accordance with ASA rules with the following modifications.” Clearly list all modifications and include game time limits.
    - Map to the fields if more than one site is being used.
    - The tiebreaker procedure shall be used to resolve ties in pool play as follows: 1. Head to Head play. 2. Lowest total runs allowed in pool play games. 3. Total runs scored in all pool play games. 4. Coin toss.
    - Individual copy of the bracket.

14. When a run limit per inning rule is utilized and a team is behind more runs than are allowed per inning, the game may be called at the game time limit.

15. It is recommended that Tournament Directors not use “imaginary fences”.

16. It is recommended that awards be provided based upon the number of entries in the tournament.

1st Place:	4 or less teams	Team award and individual awards
	5 or more teams	Team award and individual awards
2nd Place:	4 or less teams	Team award
	5 or more teams	Team award and individual awards

17. A league may request permission to host a combined classification tournament when submitting their league's Tournament Request Form. It will be up to the Tournament Scheduling Committee to determine approval of the event. No second league tournament will be allowed once tournament season starts.

NON-CHAMPIONSHIP YOUTH EVENT

In addition to the above:

1. Tournament Directors are required to carry ASA tournament liability insurance or other coverage, such as Additional Named Insured only if ALL players, coaches and umpires are registered ASA.

2. The Tournament Director will receive an information packet 30 days prior to the tournament with the UIC'S name and phone number, applicable fees, and tournament responsibilities.

3. The UIC will contact the Tournament Director 14 days prior to the event to ascertain the possible number of teams, fields that will be used, the estimated starting times and whether lunch will be available at all sites and provided to umpires. 7 days prior to the event, the Tournament Director will report to the UIC the final number of fields to be used; the Tournament Director may not schedule additional fields.

4. Player Eligibility - CCASA requires that ASA Code and Rules of player Eligibility be followed. The Tournament Directors must require some type of roster that lists name, address, and provides proof of birth date. A signed championship roster is not required.

5. Any team that has their roster and fees in by the tournament deadline cannot be refused entry into a sanctioned event unless the maximum number of teams has already been reached**.** Any team may play up in classification but are subject to reclassification based on tournament performance and is at the discretion of the classification committee.

6. Before game scheduling, the tournament Director is responsible for verifying all teams accepted meet classification and division requirements for the entry submitted. ***Tournament directors are to contact CCASA staff as directed in their tournament information packet for team verification.***

7. All sanctioned youth tournaments will be assigned an umpire-in-chief by CCASA Staff. Staff will coordinate umpires for the event through the event UIC. Event UIC will be on site to handle protests, collect fees, and report to CCASA any problems that were encountered. CCASA establishes umpire per game rate for youth sanctioned events. Confirm this with your UIC**.** Payment may be in cash or by individual checks and is due to the UIC Saturday after lunch. It is the responsibility of the UIC to pay the game umpires.

8. All sanctioned youth events are required to have two umpires assigned to each game and 3 umpires assigned to the Championship and "if" games.

9. Tournament Directors are required to provide adequate shade and water for umpires working the games.

10. Scheduling

    A. Game Time Limit: A minimum of 1:20 with no new inning beginning after time has expired. Innings started before the time limit expired must be completed.

    1. Exception: There will be no restrictions on time limits or schedules for "A" tournaments.

    B. Game Schedule: A minimum of 20 minutes must be allowed between the scheduled end time of the previous game and the start of the next game. ***Games cannot be scheduled later than 4pm on Sunday.***

    C. Tournament locations with no hot food available on site will schedule an extra 45 minutes for a lunch break.

    D. Number of scheduled fields cannot exceed those requested and approved by the tournament scheduling committee. Refer to addendum 1 for sample tournament capacity information.

11. Sanctioned "C" 10U division tournaments may use the 11-inch SOFTY ball. All "B" 10U tournaments must use the 11-inch hardball.

12. Sanctioned tournaments fees have no cap.

13. **8U Rules**: See separate 8U Rules located on www.centralcalasa.com

Addendum 1

Tournament capacity Information

Tournament capacity formulas:

4 game guarantee - Fields (times) Fri/Sat Game Slots (divided by) 1.5 = Max Teams*
3 game guarantee - Fields (times) Fri/Sat Game Slots = Max Teams*

Example: Your tournament will be a 4 game guarantee with pool play and single elimination. Your facility has 5 fields and you will have a Friday game time at 6 and Saturday game times at 8, 10, 12, 2, 4 and 6. That's 5 fields with 7 game slots.

4 game guarantee - 5X7=35/1.5=23 Max Teams*

3 game guarantee - 5X7=35= Max Teams*

* Max teams cannot be finalized until Sunday pool play is rough bracketed keeping in mind that no games can be scheduled after 4 pm on Sunday.