CERTIFICATE OF LIABILITY INSURANCE

DATE: 1/24/2012

PRODUCER:

Chappell Insurance Agency, Inc.
25807-A Cox Road
Petersburg, VA 23803
(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:

Nations Baseball Tournament Association, Inc.
216 Statesville Blvd.
Salisbury, NC 28144 USA
A Member of the Athletic Alliance RPG
TEAM NAME: 19U Skyway Youth Baseball and Softball, Inc

INSURERS AFFORDING COVERAGE

INSURER A:	Nationwide Mutual Insurance Company
INSURER B:	Hartford Life and Accident Company
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGE'S

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	ADDL INSD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		**GENERAL LIABILITY**				EACH OCCURRENCE	$2,000,000.00
		[X] COMMERCIAL GENERAL LIABILITY	6B RPG-0000025319000	1/1/2012	1/1/2013	DAMAGE TO RENTED PREMISES (EA OCC)	$300,000.00
		[ ] CLAIMS MADE				MED EXP (Any one person)	EXCLUDED
		[X] OCCUR				PERSONAL & ADV INJURY	$2,000,000.00
		[ ] _____				GENERAL AGGREGATE	$5,000,000.00
						PRODUCTS-COMP/OP AGG	$2,000,000.00
						PARTICIPANT LEGAL LIAB.	$2,000,000.00
		AUTOMOBILE LIABILITY					
		[ ] ANY AUTO				COMBINED SINGLE LIMIT (Ea accident)	$
		[ ] ALL OWNED AUTOS				BODILY INJURY (Per Person)	$
		[ ] SCHEDULED AUTOS				BODILY INJURY (Per Accident)	$
		[ ] HIRED AUTOS				PROPERTY DAMAGE (Per Accident)	$
		[ ] NON-OWNED AUTOS					
		[ ] _____					
B		**SECONDARY PARTICIPANT ACCIDENT**	36-SB-204963	1/1/2012	1/1/2013	AD&D	$5,000.00
						Excess Accident Medical Expense	$100,000.00
						Deductible	$250.00
						Benefit Period	52 Weeks

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

The team or league listed below as a certificate holder is a named insured within the above referenced policies for any Nations Baseball league play, tournament advancement, and practice.

Coverage effective from: 1/12/2012 - 01/01/2013

CERTIFICATE HOLDER

Skyway Youth Baseball and Softball, Inc
8303 Archwood Circle
Tampa, FL 33615

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.

Certificate Number: Nations-BB-90-024032

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE: 1/24/2012

PRODUCER:

Chappell Insurance Agency, Inc.
25807-A Cox Road
Petersburg, VA 23803
(804) 733-2020

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

The association shown as a certificateholder is an additional insured as respects the insureds negligence resulting from the insureds' participation in events sanctioned and operated by the certificateholder. The additional insured status only applies during such times that the insured participates in these events.

Coverage effective from: 01/12/12 - 01/01/2013

CERTIFICATE HOLDER

Skyway Park Board of Directors as a third party to
Hillsborough County BOCC
4840 Independence Parkway
Tampa, FL 33624

CANCELLATION

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

The county shown as a certificateholder is an additional insured as respects the insureds negligence resulting from the insureds' usage of owned or controlled premises of the certificateholder. The additional insured status only applies during such times that the insured is utilizing said premises.

Coverage effective from: 01/24/12 - 01/01/2013

CERTIFICATE HOLDER

Skyway Youth Baseball and Softball, Inc Board of Directors
as a third party to Hillsborough County BOCC
4840 Independence Parkway
Tampa, VA 22624

CANCELLATION

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Certificate Number: Nations-BB-90-024032

AUTHORIZED REPRESENTATIVE

How to File a Medical Claim
Nations Baseball Tournament Association, Inc.

Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy

Please forward claims and questions to the following address:

Hartford Life Claims
P. O. Box 3856
Alpharetta, GA 30023
Toll Free: (800) 678-6702 Fax: (866) 954-3993

Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail

The Policyholder (Coach or Tournament Director) not the Parent, Claimant or Agent should:

- Fully answer/sign each item in the Policyholder Certification section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

The Parent/Guardian or Adult Claimant should:

- Fully answer/sign each item in the Claimant Certification section (choose either the Parent/Guardian column or the Adult Claimant column; which ever is applicable).
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

Step 2 - Submit itemized medical bills for payment consideration to our office. This policy is written on an Excess basis, so please include any other insurance carrier's corresponding Explanation of Benefits (EOBs) as outlined in the helpful information bullet listed below.

Helpful information for submitting claims and expediting payment

- A fully completed Notice of Claim is required for each accident/injury a Claimant incurs. Claims submitted with incomplete information will be denied pending receipt of the missing data.
- Release of claim forms by an insurance company is not an admission of coverage. In addition, information on the form is subject to audit by the insurance company.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- For Excess policies, if the Claimant has other insurance coverage, medical bills must first be submitted to your other insurance carrier for payment. Once they have processed the charges (either paid or denied), then submit a copy of your provider's itemized medical bill and the other carrier's coordinating Explanation of Benefits (EOB) to our office for processing. Important - we are unable to make a claim determination without both of these items; claim payment will be expedited if the medical bill and EOB are submitted at the same time.
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY

Notice of Claim

NATIONS BASEBALL TOURNAMENT ASSOCIATION, INC.

P. O. Box 3856, Alpharetta, GA 30023, Toll Free: (800) 678-6702 Fax: (866) 954-3993

POLICYHOLDER CERTIFICATION - To be completed by Policyholder (Coach or Tournament Director)

Policyholder Number	Team Name and Certificate Number	Team Manager Name
36-SB-204963		

Policyholder Name	Coach or Tournament Director's Phone Number
Nations Baseball Tournament Association, Inc.	( )

Policyholder Address (Street, City, State & Zip Code)
10801 Hammerly Road, Suite 210, Houston, TX 77043

Claimant (Injured Party) Name	Claimant is
	☐ Player ☐ Coach ☐ Umpire ☐ Other _____

Injured body parts _____ ☐ Left ☐ Right

Place of Accident	Cause of Accident	
	Claimant was	Claimant was hit by
☐ Game	☐ Throwing	☐ Bat
☐ Practice	☐ Sliding	☐ Batted ball
☐ Travel	☐ Fell	☐ Thrown ball ☐ Other _____
☐ Other _____		

Date of Accident (mm/dd/yyyy)	Time of Accident (hh:mm)
_____	_____ ☐ AM ☐ PM

Policyholder Certification Statement (Signature Required)

I hereby certify the Claimant is a member of the group insured under the above Policy and the injury was sustained under adequate supervision while participating in an official Covered Activity. I further certify I have read and signed the Fraud Warning statement located on the reverse side of this form.

_____ _____
Policyholder Signature (Coach or Tournament Director) Date

CLAIMANT CERTIFICATION - To be completed by Parent/Guardian or Adult Claimant

New government regulations require Social Security Numbers for all claimants. Claims submitted without this will be returned.

Parent/Guardian completes for dependent child		***Adult Claimant completes***	
Claimant (Dependent child) Name	Claimant Gender ☐ Male ☐ Female	Claimant (Dependent child) Name	Claimant Gender ☐ Male ☐ Female
Claimant (Dependent child) Social Security Number		Claimant Social Security Number	
Claimant Date of Birth	Daytime Phone Number	Claimant Date of Birth	Daytime Phone Number
Claimant Address (Street Number, City, State, Zip)		ClaimantAddress (Street Number, City, State, Zip)	

Does the Claimant have medical coverage through?			Do you have medical coverage through?		
Mother's employers policy*	☐ Yes	☐ No	Your employer*	☐ Yes	☐ No
Father's employers policy*	☐ Yes	☐ No	Spouse's employer*	☐ Yes	☐ No
Guardian's employers policy*	☐ Yes	☐ No	Medicare policy	☐ Yes	☐ No
Medicare policy	☐ Yes	☐ No	Medicaid policy	☐ Yes	☐ No
Medicaid policy	☐ Yes	☐ No	Any other medical policy*	☐ Yes	☐ No
Any other medical policy*	☐ Yes	☐ No			
*If yes, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.			*If yes, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.		

Parent/Guardian Certification Statement (Signature Required)

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have read and signed the Fraud Warning Certification statement located on the reverse side of this form. I also authorize any physician / hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

_____ _____ _____
Printed Name of Parent/Guardian or Adult Claimant Signature of Parent/Guardian or Adult Claimant Date

Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____ _____

Signature of Policyholder Official Date

_____ _____

Signature of Parent/Guardian or Adult Claimant Date