



POP WARNER Little Scholars, Inc.



Thank you for allowing us to provide your insurance this year.

Please find your Welcome Packet attached. Your certificates will be sent under separate cover.

If you should have any questions, please contact Beth Dietz at the Pop Warner Office.

Beth Dietz
National Events Manager
Ph: 215-752-2691 x 22
Fax: 215-752-2879
bethdietz@popwarner.com



AIG Domestic Accident & Health Division

A Division of American International Companies®

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: **Pop Warner Little Scholars, Inc.**
Policy Number: **SRG 9108336**

BLANKET ACCIDENT INSURANCE

DESCRIPTION OF COVERAGE

Who Is Eligible:

If you are a registered player or cheerleader of an insured team of the Policyholder (Pop Warner Little Scholars, Inc./ Pop Warner,) while participating in Pop Warner sponsored play, practice, try-outs, play-offs, approved banquets, meetings and fund raisers and all Pop Warner team coaches, managers, adult volunteers, and hired game officials.

What Activities Are Covered:

You are covered while participating in 1) activities sponsored and supervised by Pop Warner; 2) traveling to, during or after such activities as a member of a group in transportation furnished or arranged by Pop Warner; and 3) traveling directly to or from your home premises and the site of such activities.

Your Effective and Termination Dates:

Effective Date. Your coverage under the Policy begins, provided premiums have been paid by You or on Your behalf, on the later of: 1) the date You become a member of Pop Warner Little Scholars, Inc./Pop Warner; 2) the date for which the first premium for Your coverage is paid; or 3) the date the Policy becomes effective.

Termination Date. Your coverage under the Policy ends on the earliest of: (1) the date the Policy is terminated, (2) the end of the period for which Your premiums have been paid; or (3) the date You cease to be a member of Pop Warner Little Scholars, Inc./Pop Warner.

SCHEDULE OF BENEFITS

<u>BENEFIT</u>	<u>MAXIMUM AMOUNT</u>
Accidental Death	\$10,000
Accidental Dismemberment	\$10,000
Heart or Circulatory Benefit	\$10,000
Commencement Period	Within 48 hours after participation
Pre-Existing Conditions	5 years prior contestable period
Aggregate Limit (Applicable to Accidental Death & Dismemberment)	\$500,000
Accident Medical Expense – Excess	\$100,000
Commencement Period	90 days
Incurred Period (Maximum Benefit Period)	104 Weeks
Deductible	\$0.00 per accident
Dental Maximum	\$250 per tooth per accident
Emergency Evacuation with Family Travel	\$25,000
Repatriation of Remains	\$10,000
*Weekly Accident Indemnity	\$50.00 per week
Commencement Period	90 days
Elimination Period (waiting period)	7 days
Incurred Period (Maximum Benefit Period)	26 weeks

*Weekly Accident Indemnity Benefit is applicable to team coaches, managers, adult volunteers and hired game officials only.

Definitions:

Injury - means bodily injury: (1) which is sustained as a direct result of an accident that is external to the body and that occurs while such person's coverage under this Policy is in force; and (2) which occurs while such person is participating in a Covered Activity; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

Immediate Family Member - means a person who is related to You or Your spouse in any of the following ways: spouse, child, parent, brother or sister, or persons who ordinarily reside in Your household.

Physician - means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) You; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Description of Coverage:

The Maximum Amounts as shown above in the Schedule of Benefits are used to determine amounts payable under each Benefit. Actual amounts payable will not exceed the maximums, and may be less than the maximums under circumstances specified in the Policy.

Accidental Death and Accidental Dismemberment Benefit. If You suffer an Injury that, within 365 days of the date of the accident that caused the Injury, results in a covered loss, the Company will pay the following percentage of the Maximum Amount for that loss.

<u>For Loss of:</u>	<u>Percentage of Maximum Amount</u>
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye.....	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
The Sight of One Eye.....	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means total and irrecoverable loss of the entire ability to speak. “Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If You sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Heart and/or Circulatory Benefit. If you suffer a heart and/or circulatory malfunction that results in death as a direct result of participating in a Covered Activity, the Policy will pay the Loss of Life benefit amount, \$10,000, provided that: (1) the symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to such Insured and within 48 hours after such participation, and (2) such Insured has not, within the last five (5) years prior to the date of such participation in the Covered Activity, been medically advised that he/she has been diagnosed with, or has received any medication for any myocardial infarction, angina pectoris, coronary thrombosis or a cerebral vascular incident, unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription.

Accident Medical Expense Benefit. If You suffer an Injury that, within 90 days of the date of the accident that caused the Injury, requires You to be treated by a Physician, the Company will pay the Usual and Customary charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Amount per person. This benefit is payable only for such charges incurred within 104 weeks after the date of the accident causing that Injury.

Covered Accident Medical Service(s) are: hospital semi-private room and board (or room and board in an intensive care unit); hospital ancillary services (including, but not limited to, use of the operating room or emergency room); use of an ambulatory medical center; services of a Physician or a registered nurse (R.N.); ambulance service to or from a Hospital; laboratory tests; radiological procedures; anesthetics and the administration of anesthetics; blood, blood products and artificial blood products, and the transfusion thereof; physical therapy and occupational therapy; rental of Durable Medical Equipment; artificial limbs, artificial eyes or other prosthetic appliances; or medicines or drugs administered by a physician or that can be obtained only with a physician’s written prescription.

In addition to the standard exclusions, Accident Medical Expense benefits are not payable for any expense for or resulting from any of the following: (1) repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition; (2) new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except up to the Dental Maximum shown in the Schedule of Benefits for repair or replacement of sound natural teeth damaged or lost as a result of Injury; (3) new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight; (4) new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing; (5) rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary covered Accident Medical Expense in lieu of such rental expense); (6) personal comfort or convenience items, such as but not limited to hospital telephone charges, television rental, or guest meals; (7) an Emergency Evacuation for which any benefits are payable under the Emergency Evacuation Benefit; (8) any condition for which You are entitled to benefits under any Workers' Compensation Act or similar law.

Accident Medical Expenses are payable only in excess of any expenses payable by other valid and collectible group insurance.

Ambulatory Medical Center - means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Deductible - means the amount of Usual and Customary Charges for medically necessary Covered Accident Medical Services that must be incurred by You due to Injuries resulting from an accident before Accident Medical Expense benefits become payable due to Injuries resulting from that accident. The Deductible amount is shown in the Schedule of Benefits. Accident Medical Expense benefits are not payable for charges applied to the Deductible.

Durable Medical Equipment - means equipment of a type that is designed primarily for use, and used primarily, by people who are injured (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Hospital - means a facility which: (1) is operated pursuant to law and which is licensed or approved as a hospital by the responsible state agency; (2) is primarily engaged in providing medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and (3) provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.). A Hospital does not include: (1) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces; (2) convalescent homes, convalescent, rest, or nursing facilities; or (3) facilities primarily for the aged, drug or alcoholic rehabilitation, and those primarily affording custodial or educational care.

Medically Necessary - means that a Covered Accident Medical Service is: (1) is essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

Usual and Customary Charge(s) - means a charge that: is made for a Covered Accident Medical Service; does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a hospital room and board charge, other than for a medically necessary stay in an intensive care unit, does not exceed the hospital's most common charge for semi-private room and board); and does not include charges that would not have been made if no insurance existed.

Emergency Evacuation Benefit. The Company will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to the Maximum Amount, if You suffer an Injury or Emergency Sickness that warrants Your Emergency Evacuation while You are outside a 100 mile radius from Your current place of primary residence.

The Emergency Evacuation must be ordered by a Physician who certifies that the severity of Your Injury or Emergency Sickness warrants Your Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

AIG Assist must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AIG Assist in advance.

Covered Emergency Evacuation Expense(s) - means an expense that: (1) is charged for a Medically Necessary Emergency Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Emergency Evacuation - means, if warranted by the severity of Your Injury or Emergency Sickness: Your immediate transportation from the place where You suffer an Injury or Emergency Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained; and/or Your transportation to Your current place of primary residence to obtain further medical treatment in a hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility. An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Emergency Sickness - means an illness or disease, diagnosed by a physician, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of Your condition or place Your life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while Your coverage under the Policy is in force and while You are participating in a Covered Activity.

Medically Necessary Emergency Evacuation Service - means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting You.

Transportation - means moving You during an Emergency Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Repatriation of Remains Benefit. If You suffer loss of life due to Injury while outside a 100 mile radius from Your current place of primary residence, the Company will pay for covered expenses reasonably incurred to return Your body to Your current place of primary residence, but not exceeding the Maximum Amount.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

AIG Assist must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AIG Assist in advance.

The sickness exclusion does not apply with respect to Repatriation of Remains benefit. In addition to the standard exclusions, Repatriation of Remains benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which You are entitled to benefits under any Workers' Compensation Act or similar law.

Weekly Accident Indemnity Benefit. If, as a result of an Injury, You are rendered Totally Disabled within 30 days of the accident that caused the Injury, the Company will pay a benefit after 7 day(s) of Total Disability due to that Injury in any one Period of Disability. The amount of the benefit per week is the lesser of: (1) the Weekly Maximum Amount shown for the Weekly Accident Indemnity Benefit in the Schedule of Benefits. It is payable weekly so long as You remain Totally Disabled due to that Injury in that Period of Disability, up to the Maximum Number of Weeks shown for the Weekly Accident Indemnity Benefit in the Schedule of Benefits in all Periods of Disability resulting from all Injuries caused by the same accident. The Company will pay benefits calculated at a rate of 1/7th of the weekly benefit for each day of Total Disability for which the Company is liable when You are Totally Disabled for less than a full week. Only one benefit is provided for any one day of Total Disability, regardless of the number of Injuries causing the Total Disability. No benefits are payable if You had no earnings at the time of the accident causing the Injury from an occupation, job or work being performed at that time.

If You return to perform the material and substantial duties of Your occupation for any employer on a full or part-time basis, You may return to Total Disability status if: (1) You have not been back to work for longer than 30 days; and (2) You are again Totally Disabled due to the same Injury which caused the original Total Disability.

Periods of Total Disability separated by less than 30 consecutive days will be considered one period of disability unless due to separate and unrelated causes.

The Company reserves the right (as often as it may reasonably require) to determine, on the basis of all the facts and circumstances, that You are Totally Disabled, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

Occupation - means the occupation, job or work You performed at the time of the accident causing the Injury for which Weekly Accident Indemnity benefits are claimed.

Period of Disability - means a period of consecutive days of continuous Total Disability.

Totally Disabled/Total Disability - means that You are unable to perform the material and substantial duties of Your Occupation for any employer.

Weekly Earnings - means Your base weekly earnings in Your Occupation at the time of the accident causing the Injury for which benefits are claimed, but not including overtime, bonuses, tips, commissions, and special compensation.

Aggregate Limit:

The aggregate limit of indemnity for which the Company shall be liable with respect to Injuries sustained by more than one insured as a result of the same accident will not exceed the amount shown as the Aggregate Limit.

Limitation on Multiple Benefits:

If You suffer one or more losses from the same accident for which amounts are payable under more than one of the following benefits provided by the Policy, the Maximum Amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit.

Exposure and Disappearance:

If by reason of an accident occurring while Your coverage is in force under the Policy, You are unavoidably exposed to the elements and, as a result of such exposure, suffer a loss for which a benefit is otherwise payable, the loss will be covered according to the terms of the Policy.

If Your body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant while covered under the Policy, it will be deemed, subject to all other terms and provisions of the Policy, that You have suffered Accidental Death.

Exclusions:

No coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from or contributed to by, or as a natural and probable consequence of any of the following excluded risks (even if the proximate or precipitating cause of the loss is an accidental bodily Injury: 1) suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury; 2) sickness, or disease whether the loss results directly or indirectly from any of these; 3) the Insured's commission of or attempt to commit a felony; 4) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes; 5) declared or undeclared war, or any act of declared or undeclared war, except if specifically provided by this Policy; 6) participation in any team sport or any other athletic activity, except participation in a Covered Activity; 7) full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured is not covered due to his or her active duty status will be refunded) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded); 8) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured is: a) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; b) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or c) riding as a passenger in an aircraft owned, leased or operated by the Policyholder or the Insured's employer; 9) the Insured being under the influence of drugs or intoxicants unless taken under the advice of and as specified by a Physician; 10) any condition for which the Insured is entitled to benefits under any Workers' compensation Act or similar law.

Claims Procedures:

All claims should be reported to the Claims Administrator as soon as possible at the following phone number or by writing to the following address:

NAHGA Claim Services
P.O. Box 189
Bridgton, Maine 04009-0189

800-952-4320 Phone
207-647-4569 Fax

Complete and submit a claim reporting form, providing the policy number and any applicable documentation and details describing the nature of the loss. Upon receipt of this information, the Claims Administrator will issue an acknowledgement letter and case number. You must submit all medical bills to any primary insurance policy that covers the injured party. Then submit the primary insurance Explanation of Benefits (EOB), along with itemized medical bills, to the Claims Administrator. Claim payments will be made immediately upon receipt of written proof of loss, except with regard to periodic claim payments. Claim payments will be made to the Medical Providers, unless a paid receipt is submitted with your medical bills. Death claims will be paid, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is Your estate. Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

AIG ASSIST - TRAVEL ASSISTANCE SERVICES

AIG Assist, **1-800-626-2427**, must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation or Repatriation of Remains Benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact AIG Assist in advance. AIG Assist offers the following services to Insureds whenever they travel a distance of 100 miles or more away from their primary residence or permanent place of assignment: Medical Emergency Services, Legal Referral Assistance, Emergency Evacuation/Repatriation Assistance, Lost Luggage Assistance, Emergency Travel Agency Services, Emergency Message Service, Emergency Translation Service, Pre-Trip Assistance.

IMPORTANT

If any conflict should arise between the contents of this Description of Coverage and the Master Policy, **SRG 9108336**, or if any point is not covered herein, the terms and conditions of the Master Policy will govern in all cases.

LIABILITY INSURANCE

Purpose of Coverage: Commercial General Liability insurance covers claims for legal liability arising from bodily injury, property damage, and personal injury. There is a \$1,000,000 per occurrence limit / \$5,000,000 aggregate limit. There also is an option to increase the limit to \$2,000,000 per occurrence. See enrollment for rates.

Who is Protected

- A. Insured: Coverage is provided for the insured Camp, volunteers, managers, coaches, game officials, and other managing personnel and auxiliaries, while acting on behalf of the insured Camp during sponsored events.
- B. Additional Insured: Coverage as an "Additional Insured" may also be afforded to playing facilities such as those owned by cities, municipalities, school districts, etc. Coverage for Additional Insureds may be requested on Section V of the application.

Major Coverages Afforded by This Policy

- Participants Legal Liability
- Sexual Abuse/Molestation (\$1,000,000 per occurrence / \$1,000,000 policy aggregate)
- Ownership, maintenance, or use of football fields, stands and playing areas by the camp
- All activities necessary or incidental to the conduct of camp practice, exhibition and scheduled camp events
- Consumption or use of food products
- Fund-raising, meetings, and awards banquets (camp sponsored events)
- Cost of investigation and defense against claims
- Liability assumed under insured written contracts
- Legal Liability for libel, slander, defamation of character, wrongful eviction, and invasion of privacy

Major Exclusions in this Policy

- The use of automobiles, buses, watercraft and aircraft
- Property of others in the care, custody, and control of the insured
- Injury or death of an employee

Additional Insured Certificates: Field owners and qualified others may have liability coverage extended to them FREE OF CHARGE. However, in order to obtain this benefit, their complete names, addresses, and relationship to you (e.g. "field owner") must be listed in the box provided on the reverse side of the "Enrollment Form" at the time you submit your enrollment form, your request must be made to Pop Warner. All other requests must be made to Pop Warner: (215) 752-2691

This is only a brief description of the coverage available under this Policy. The Policy may contain reductions, limitations, exclusions, and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this document and the Policy, or if any point is not covered in this document, the terms and conditions of the Policy will govern in all cases.

Disclaimer

U. S. risks placed with a surplus lines insurer must be placed in accordance with state and federal law, including applicable surplus lines laws. Surplus lines insurers do not generally participate in State Guaranty Funds and thus insureds are not protected by such funds. The surplus lines market is a brokered market providing flexibility in rate and form to meet customer needs for high risk and specialized insurance products. All submissions to surplus lines insurers are subject to underwriting by the insurer. Products may not be available in all states. The information contained herein is for general information purposes only and does not constitute an offer to sell or a solicitation. Inquires should be directed to your local insurance broker.

INSTRUCTIONS TO REQUEST CERTIFICATES OF INSURANCE

If you need an additional insured certificate, you must fill out a Request for Certificate of Insurance Form. We do not take information over the phone. The following outlines the process for filling out the form correctly. Please print or type.

1. Write your league name along with your association's name as it appears on your Certificate and include your address.
2. Enter the date of request along with the date the certificate is needed by.
3. Enter your full name and a phone number where you can be reached. If you would like the certificate faxed to you, please provide your fax number.
4. For coverage needed, check General Liability. If the additional insured requires anything else, check that also.
5. If this request is not for a specific event, skip to section 5-8 on the form.
6. If this request is for a specific event, write in the name of the event, the date(s) of the event, and the site or location of the event. Then check YES or NO for #4.
7. In section 5-9, write in the entity (i.e. person, place, organization) that is requiring the certificate along with the entity's address. If you would like a certificate faxed to that entity, provide their fax number and a contact person to whom the fax would go to.
8. In section 10-11, check YES if the entity (i.e. person, place, organization) is requiring additional insured status; if they are not, check NO. If YES is checked, and the entity requires additional wording (i.e. officers, employees, agents, other), write this information in section 10.
9. For #11, indicate the relationship between Pop Warner and the additional insured (i.e. field owner, facility owner, sponsor, other).
10. When requesting duplicate certificates of insurance please refer to the certificate number. Please see below for location of certificate number.

CERTIFICATE HOLDER & ADDITIONAL INSURED. INSURER LETTER: A	CANCELLATION
ABC CERTIFICATE HOLDER ANY STREET ANY TOWN, USA	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

CERT # 0123-2009-1234

POP WARNER LITTLE SCHOLARS, INC.
REQUEST FOR CERTIFICATE OF INSURANCE

(This form is only utilized when a facility/organization requires a certificate of insurance)

League: _____ Association: _____

Association Address: _____

Date of request: _____ Date certificate needed by: _____

Name of person completing form: _____

Phone: _____ Fax: _____

Coverage Needed: General Liability (\$1,000,000 limit) Excess (\$2,000,000 limit)

If this is a request for an EVENT please complete this section, if not skip to number 5.

1. Name of event: _____

2. Date(s) of event: _____

3. Site of location of event: _____

4. Is the insured the primary host for the event? Yes No

5. Certificate Holder: _____

6. Certificate Holder address: _____

7. Certificate Holder phone: () _____ Fax: () _____

8. Contact Person: _____

9. E-mail Address: _____

10. Does the Certificate Holder require additional insured* status? Yes No
If yes, please specify Additional Insured wording:

*Additional insured should only be checked if it is a requirement of the Certificate Holder.

11. If number 10 has been checked, please outline the role the Additional Insured is playing in the activity (i.e. field owner, sponsor, other):

12. **Original certificate will be sent to the League/Association Insurance Coordinator**

Please forward completed request to: **Beth Dietz**
Pop Warner Little Scholars, Inc.
586 Middleton Blvd., Suite C-100
Langhorne, PA 19047
Ph 215-752-2691 x22; Fax 215-752-2879
bethdietz@popwarner.com

**POP WARNER
FACILITY SAFETY CHECKLIST**

Inspector:

Date:

Facility Name/Location:

*** If the answer to any of the questions below is "no," corrective action must be taken ***

ATHLETE AREAS

<p>Playing Surface:</p> <ol style="list-style-type: none"> Playing surface is in proper condition: <ul style="list-style-type: none"> Field: free of large divots or holes Gym: dry and clean <input type="checkbox"/> Yes <input type="checkbox"/> No Playing surface is free of obstructions and protruding objects (e.g. sprinkler heads, soccer goals, basketball nets, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Out-of-bounds areas are free of obstructions and protruding objects <input type="checkbox"/> Yes <input type="checkbox"/> No Playing area is clearly marked <input type="checkbox"/> Yes <input type="checkbox"/> No Lighting appears adequate <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Corrective Action Needed:</p> <p>Corrective Action Taken:</p>	<p>Locker Rooms:</p> <ol style="list-style-type: none"> Floors are dry <input type="checkbox"/> Yes <input type="checkbox"/> No Lockers are secure and free of laceration exposures <input type="checkbox"/> Yes <input type="checkbox"/> No Bathrooms appear sanitary <input type="checkbox"/> Yes <input type="checkbox"/> No Housekeeping in locker room area is in order <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Corrective Action Needed:</p> <p>Corrective Action Taken:</p>
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EMERGENCY RESPONSE

<p>Access to Emergency Service:</p> <ol style="list-style-type: none"> Telephones and the appropriate emergency numbers are accessible <input type="checkbox"/> Yes <input type="checkbox"/> No There is adequate passage for emergency vehicles <input type="checkbox"/> Yes <input type="checkbox"/> No Players' medical history forms are on site <input type="checkbox"/> Yes <input type="checkbox"/> No Players' emergency contact lists are on site <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Corrective Action Needed:</p> <p>Corrective Action Taken:</p>	<p>First Aid Equipment Checklist:</p> <ul style="list-style-type: none"> <input type="checkbox"/> List of athletes with special conditions (asthma, epilepsy, diabetes, allergies, etc.) <input type="checkbox"/> List of emergency phone numbers <input type="checkbox"/> Adhesive bandages with gauze pads – assorted sizes <input type="checkbox"/> Antiseptic <input type="checkbox"/> Arm sling (triangular bandage is fine) <input type="checkbox"/> Bandage scissors <input type="checkbox"/> Butterfly closures <input type="checkbox"/> Cotton swabs <input type="checkbox"/> Elastic tape <input type="checkbox"/> White tape <input type="checkbox"/> Elastic wraps <input type="checkbox"/> Emergency blanket <input type="checkbox"/> Latex gloves (multiple pairs) <input type="checkbox"/> Plastic bags and bags for ice packs <input type="checkbox"/> Sterile Water <input type="checkbox"/> Resuscitation (CPR) masks/face shield
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SPECTATOR AREAS

*** This section may apply to coaches or administrators, depending on who has the responsibility in their local Pop Warner program ***

<p>Areas Adjacent to Field or Gym:</p> <ol style="list-style-type: none"> Adequate number of waste containers in place <input type="checkbox"/> Yes <input type="checkbox"/> No Areas are free of slip, trip and fall hazards <input type="checkbox"/> Yes <input type="checkbox"/> No Water fountain areas are free of puddles, algae build up and/or mud <input type="checkbox"/> Yes <input type="checkbox"/> No Barriers to protect spectators are adequate and in good condition <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Corrective Action Needed:</p>	<p>Parking Lot:</p> <ol style="list-style-type: none"> Lighting appears adequate <input type="checkbox"/> Yes <input type="checkbox"/> No Area is free of slip, trip and fall hazards <input type="checkbox"/> Yes <input type="checkbox"/> No Security is present <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <p>Corrective Action Needed:</p> <p>Corrective Action Taken:</p>
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Over → →

Corrective Action Taken:	
<p>Bleachers:</p> <ol style="list-style-type: none"> 1. Footers are blocked appropriately and do not move. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Vertical openings between guardrails, footboards and seatboards are less than four inches <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Metal bleachers are free of corrosion and/or damage <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Wood bleachers are free of dry rot and/or damage <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Transitional areas are clearly marked <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Handrails, seats and supports are securely fastened <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Seats and handrails are free from splinters <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Bleachers appear sturdy enough for anticipated loads <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Corrective Action Needed:</p> <p>Corrective Action Taken:</p>	<p>Walkways, Steps, Stairs, Ramps:</p> <ol style="list-style-type: none"> 1. Walking areas are free of slip, trip and fall hazards <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Transitional areas are clearly marked <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Lighting appears adequate <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Handrails are securely fastened <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Areas are free of trash, debris and other obstructions <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Sufficient trash containers are provided <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Entrance/exit areas are accessible <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Corrective Action Needed:</p> <p>Corrective Action Taken:</p>

POP WARNER CLAIM SUBMISSION PROCESS

Excess Medical

Pop Warner Little Scholars, Inc., provides excess accident coverage for registered participants through AIG Insurance. The excess policy covers accidents that occur during sponsored activities and is secondary to the participants' group medical insurance.

When a player is injured, all medical bills must first be submitted to the primary insurance. As soon as possible after an accident, the injured player, or parents, if the player is a minor, must call NAHGA Claim Services at 800-952-4320 to request a claim form. The claim form can also be obtained by downloading from the website www.popwarner.com.

A representative of the league, coach or league official, must complete and sign Part 2 of the claim form. This is for verification purposes to confirm that the player was injured while participating in a sponsored event. The injured player, or parent, must complete Parts 1, 3, 4 and 5. Please submit the completed Pop Warner form as soon after the injury as possible.

Once response is received from any primary insurance, please submit each itemized medical bill (a balance due statement is not sufficient) along with the corresponding primary insurance Explanation of Benefits (EOB) for each bill. If the injured player has no other insurance, that information must be noted on the claim form. The AIG policy becomes primary in the absence of other valid insurance.

If you require a(n) additional claim form(s), you may submit a photocopy of the blank original form or you may go to www.popwarner.com.

General Liability and Property

When an accident occurs a notice must be completed immediately. This holds true whether the person involved is a participant or a spectator, or whether or not you feel the incident will result in a claim.

To obtain a General Liability or Property Notice of Occurrence/ Claim form, please contact Beth Dietz at Pop Warner at 215-752-2691, ext. 22.

Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM & BILLS TO:



Underwritten by: American International Group, Inc.



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

IMPORTANT NOTICE:
If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, please send it to us with the corresponding itemized bills.

PART 1: POLICYHOLDER & INSURED

(1) School/Organization/Group Name		(2) Policy Number	
(3) Claimant - Last Name, First Name		(4) Claimant Social Security Number	(5) Claimant Type (please choose)
(6) Mailing Address where Insurance Info/Requests should be mailed		(7) City, State, Zip	
(8) Birthdate	(9) Male <input type="checkbox"/> Female <input type="checkbox"/>	(10) Home Phone	(11) Alternate Phone
(12) League (Example: Central Ohio)	(13) Association (Example: Columbus Titans)	(14) Team Description (please choose one)	
(15) If claimant is an adult, name and address of Employer:			

PART 2: INJURY DETAILS

(1) Date of Injury	(2) Time & Address where occurred?	(3) Sport (please choose one)
(4) Description of injury and how it occurred?		(5) Part of body injured
(6) Date of first medical treatment	(7) Action Taken: <input type="checkbox"/> Released to Parent <input type="checkbox"/> Ambulance Transport <input type="checkbox"/> Refused Care <input type="checkbox"/> Referred to Hospital/Clinic <input type="checkbox"/> Own Accord (Adult)	
(8) Was the claimant supervised when injured? Yes <input type="checkbox"/> No <input type="checkbox"/>		(9) Was injury during sponsored activity? Yes <input type="checkbox"/> No <input type="checkbox"/>
(10) Was injury during travel to or from scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/>		(11) If claimant is adult, is claimant unable to work as result of injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date last worked:
(12) Print Name of Supervisor/Official/Policyholder Representative	(13) Signature of Supervisor/Official/Policyholder Representative	Date

PART 3: PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)

(1) Father/Guardian Name Telephone	(7) Mother/Guardian Name Telephone
(2) Home Address (Street, City, State, Zip)	(8) Home Address (Street, City, State, Zip)
(3) Employer	(9) Employer
(4) Father's Employer Address (Street, City, State, Zip)	(10) Mother's Employer Address (Street, City, State, Zip)
(5) Business Phone	(11) Business Phone
(6) Employer Medical Insurance Policy	(12) Employer Medical Insurance Policy
(6a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>	(12a) Is Claimant covered under that policy? Yes <input type="checkbox"/> No <input type="checkbox"/>

PART 4: INSURANCE VERIFICATION

Is Claimant covered by any other insurance policy (other than this policy), either as an individual, dependent, group, automobile medical or liability? Yes No

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 5: AUTHORIZATION

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Student to disclose when requested to do so, any information to NAHGA CLAIM SERVICES 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 photo static copy of this authorization shall be considered as effective and 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

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.

Please follow these instructions to file a Claim:

- Complete front of claim form, in full;
- Sign Supervisory section, Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to NAHGA as soon as incident or illness is reported (form may be submitted without medical bills)
- Obtain and submit itemized bills, showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable).

FRAUD WARNING

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 or 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.

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: 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.

Maine, Tennessee or 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 a denial of insurance benefits.

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. (PURSUANT TO 11 NYC RR86)

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.

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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between \$5,000 and \$10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

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.

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.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.