

CCYFL

INSURANCE FORM

••• Parent or Guardian fill out the following •••

Name of Claimant: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Do you have your own insurance? Yes No

Name of Insurance Company: _____

Policy Number: _____

Have they been notified? Yes No

Date of accident: ____/____/____

Where did the accident happen? _____

What caused the accident? _____

Was the claimant taken directly to the doctor? Yes No

Parent/Guardian's Signature: _____

••• To be filled out by the head coach •••

Name of Coach: _____

Team Name: _____ Division: _____

Area Chapter: _____

Did you witness the injury? Yes No

How did the accident happen? _____

How could the injury have been avoided? _____

What medical attention was administered at the time of the injury? _____

Was the player cleared by a medical doctor to return to play? Yes No

If no, what is the expected date to return to play? ____/____/____

Coach's Signature: _____

A CCYFL "Proof of Claim" form must also accompany this form. Both forms are to be turned into the Insurance Director, who will mail them directly to the League's insurance carrier.

As insurance director for CCYFL, I authorize the processing of this claim.

Signature: _____ Date: ____/____/____