AMERICAN YOUTH FOOTBALL &
AMERICAN YOUTH CHEER

2011 SEASON PROOF OF LOSS

For Injuries which occur between 06-30-2011 and 06-29-2012
Underwritten by: ACE American Insurance Company

Send all completed forms, itemized bills, etc. to American Specialty Insurance & Risk Services, Inc. at the address shown below:

American Specialty Insurance & Risk Services, Inc.
AYF / AYC Claims Administrator
P. O. Box 459
Roanoke, IN 46783
Phone: 1-800-566-7941 Fax: 260-673-1189

PART II – PROOF OF LOSS (Must Be Completed By Injured Person or Parent/Guardian If A Minor)

IMPORTANT: This form must be completed in its ENTIRETY by the INJURED PERSON OR THE PARENT/GUARDIAN IF A MINOR.

1. NAME OF INJURED / INSURED PERSON	2. SOCIAL SECURITY NUMBER _________/_________/_________	3. SEX	4. BIRTH DATE ____/_____/____

5. MAILING ADDRESS INJURED PERSON:
Street City State Zip

6. DAYTIME TELEPHONE #: ( )	7. IS INJURED PERSON MARRIED? **Yes No**	8. IS INJURED PERSON A MINOR? **Yes No**

9. DATE AND TIME OF ACCIDENT	10. NAME / LOCATION WHERE ACCIDENT OCCURRED (Please include City & State)

10. ACTIVITY PARTICIPATING IN AT TIME OF INJURY:

11. DESCRIBE INJURY (INCLUDING PART OF BODY INJURED – SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)

12. DESCRIBE HOW ACCIDENT OCCURRED – GIVE ALL POSSIBLE DETAILS – MUST BE A BODILY INJURY DUE TO ACCIDENT

13. Is injured person a full-time student? **Yes No** If "yes", name of school attending:	14. If a full-time student, is student medical insurance available? **Yes No**
15. Does injured person have medical insurance? **Yes No** If "yes", name of company:	16. Does parent/guardian or spouse have medical insurance for the injured person? **Yes No** If "yes", name of company:
17. Does injured person have Medicaid coverage? **Yes No**	18. Does injured person have governmental funded insurance? **Yes No**

19. NAME & MAILING ADDRESS INJURED PERSON'S EMPLOYER:
Employer Name:____
Street City State Zip

20. NAME & MAILING ADDRESS INJURED SOUSE'S EMPLOYER: (IF APPLICABLE)
Employer Name:____
Street City State Zip

21. NAME & MAILING ADDRESS PARENT'S EMPLOYER (MOTHER):
Employer Name:____
Street City State Zip

22. NAME & MAILING ADDRESS PARENT'S EMPLOYER (FATHER):
Employer Name:____
Street City State Zip

23. AFFIDAVIT: I, the undersigned, affirm that I have not knowingly, or with intent, injured, defrauded, or deceived any insurance company by filing a statement of claim containing any false, incomplete, or misleading information, and understand I would be guilty of a felony by doing so.

____ ______________________
Signature of injured person (or parent/guardian if a minor) Date Signed

24. AUTHORIZATION AND ASSIGNMENT OF BENEFITS:
I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I agree that a photographic copy of this Authorization shall be as valid as the original.
I understand that I for my authorized representative may request a cop of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

25. SIGNATURE OF CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR)
DATED:

26. MAILING ADDRESS CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR)
Street City State Zip

27. DAYTIME PHONE FOR CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR) ( )	28. EMAL ADDRESS FOR CLAIMANT OR PARENT OR GUARDIAN (IF CLAIMANT IS A MINOR):

PLEASE NOTE: American Specialty Insurance & Risk Services, Inc. also conducts business as A.S.I.R.S.I. Insurance Agency in thestate of California, American Specialty Insurance & Risk Services Agency in the state of Michigan, and A.S. Insurance & Risk Services Agency in the state of New York.