

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
3/5/2010

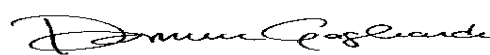
PRODUCER Gagliardi Insurance Services, Inc. 284 Digital Drive Morgan Hill, CA 95037	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
	INSURERS AFFORDING COVERAGE	NAIC #
INSURED Chandler Youth Baseball P.O. Box 6833 Chandler, AZ 85246-6833	INSURER A: The St. Paul Travelers Companies, Inc	
	INSURER B: Federal Insurance Company	20281
	INSURER C: Great American Insurance Company	
	INSURER D:	
	INSURER E:	

COVERAGES

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	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Abuse & Molestation	CK06126622	3/1/2010	3/1/2011	EACH OCCURRENCE	\$ 1,000,000
		DAMAGE TO RENTED PREMISES (Ea occurrence)				\$ 300,000	
						MED EXP (Any one person)	\$ -0-
						PERSONAL & ADV INJURY	\$ 1,000,000
						GENERAL AGGREGATE	\$ 2,000,000
						PRODUCTS - COMP/OP AGG	\$ 1,000,000
		GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				Participant Legal Liab	1,000,000
A		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	CK06126622	3/1/2010	3/1/2011	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
		BODILY INJURY (Per person)				\$	
		BODILY INJURY (Per accident)				\$	
		PROPERTY DAMAGE (Per accident)				\$	
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT	\$
						OTHER THAN AUTO ONLY: EA ACC	\$
						AGG	\$
A		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ -0-	GL06105558	3/1/2010	3/1/2011	EACH OCCURRENCE	\$ 5,000,000
		AGGREGATE				\$ 5,000,000	
							\$
							\$
							\$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS	OTHER
						E.L. EACH ACCIDENT	\$
						E.L. DISEASE - EA EMPLOYEE	\$
						E.L. DISEASE - POLICY LIMIT	\$
B		OTHER PONY BB Medical \$100 Ded	9906-4867	3/1/2010	3/1/2011	AD&D/Dental 10,000/2,000	Limit 100,000
C		Director & Officers Baseball	EPP8184838	3/1/2010	3/1/2011	Limit	1,000,000

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

CERTIFICATE HOLDER Chandler Youth Baseball P.O.Box 6833 Chandler, AZ 85246-	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. AUTHORIZED REPRESENTATIVE 
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IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

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ACORD™ CERTIFICATE OF LIABILITY INSURANCE

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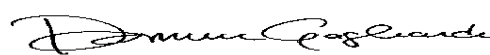
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	INSURER B: Federal Insurance Company		20281
	INSURER C: Great American Insurance Company		
	INSURER D:		
	INSURER E:		

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		DAMAGE TO RENTED PREMISES (Ea occurrence)				\$ 300,000	
		MED EXP (Any one person)				\$ -0-	
		PERSONAL & ADV INJURY				\$ 1,000,000	
		GENERAL AGGREGATE				\$ 2,000,000	
		PRODUCTS - COMP/OP AGG				\$ 1,000,000	
		Participant Legal Liab				\$ 1,000,000	
A		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	CK06126622	3/1/2010	3/1/2011	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
		BODILY INJURY (Per person)				\$	
		BODILY INJURY (Per accident)				\$	
		PROPERTY DAMAGE (Per accident)				\$	
		AUTO ONLY - EA ACCIDENT				\$	
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	\$
		AGG				\$	
						\$	
A		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ -0-	GL06105558	3/1/2010	3/1/2011	EACH OCCURRENCE	\$ 5,000,000
		AGGREGATE				\$ 5,000,000	
						\$	
						\$	
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below OTHER				WC STATUTORY LIMITS	OTHER
		E.L. EACH ACCIDENT				\$	
		E.L. DISEASE - EA EMPLOYEE				\$	
		E.L. DISEASE - POLICY LIMIT				\$	
B		PONY BB Medical \$100 Ded	9906-4867	3/1/2010	3/1/2011	AD&D/Dental 10,000/2,000	Limit 100,000
C		Director & Officers Baseball	EPP8184838	3/1/2010	3/1/2011	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 THE CITY OF CHANDLER, ITS AGENTS, REPRESENTATIVES, OFFICERS, DIRECTORS, OFFICIALS AND EMPLOYEES IS AN ADDITIONAL NAMED INSURED, BUT ONLY WITH RESPECT TO LIABILITY ARISING OUT OF OPERATIONS OF THE NAMED INSURED. ALL POLICY TERMS AND CONDITIONS APPLY.

CERTIFICATE HOLDER The City of Chandler MS 502, P.O.Box 4008 Chandler, AZ 85244-	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. AUTHORIZED REPRESENTATIVE 
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INSURED Chandler Youth Baseball P.O. Box 6833 Chandler, AZ 85246-6833	INSURER A: The St. Paul Travelers Companies, Inc		
	INSURER B: Federal Insurance Company		20281
	INSURER C: Great American Insurance Company		
	INSURER D:		
	INSURER E:		

COVERAGES

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		MED EXP (Any one person)				\$ -0-	
		PERSONAL & ADV INJURY				\$ 1,000,000	
		GENERAL AGGREGATE				\$ 2,000,000	
		PRODUCTS - COMP/OP AGG				\$ 1,000,000	
		Participant Legal Liab				\$ 1,000,000	
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		BODILY INJURY (Per person)				\$	
		BODILY INJURY (Per accident)				\$	
		PROPERTY DAMAGE (Per accident)				\$	
		AUTO ONLY - EA ACCIDENT				\$	
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	\$
		AGG				\$	
						\$	
A		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ -0-	GL06105558	3/1/2010	3/1/2011	EACH OCCURRENCE	\$ 5,000,000
		AGGREGATE				\$ 5,000,000	
						\$	
						\$	
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS	OTHER
		E.L. EACH ACCIDENT				\$	
		E.L. DISEASE - EA EMPLOYEE				\$	
		E.L. DISEASE - POLICY LIMIT				\$	
B		OTHER PONY BB Medical \$100 Ded	9906-4867	3/1/2010	3/1/2011	AD&D/Dental 10,000/2,000	Limit 100,000
C		Director & Officers Baseball	EPP8184838	3/1/2010	3/1/2011	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 CHANDLER UNIFIED SCHOOL DISTRICT IS AN ADDITIONAL NAMED INSURED, BUT ONLY WITH RESPECT TO LIABILITY ARISING OUT OF OPERATIONS OF THE NAMED INSURED. ALL POLICY TERMS AND CONDITIONS APPLY.

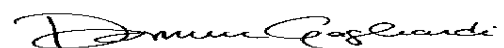
CERTIFICATE HOLDER

CANCELLATION

Chandler Unified School District
 1525 W Frye Road
 Chandler, AZ 85224-

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.

AUTHORIZED REPRESENTATIVE



IMPORTANT

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1. Please fully complete this form
 2. Please print or type except where signature is required
 3. Attach itemized bills
 4. Mail to HSR
- E-mail : gisclaims@hsri.com



HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Fax: (972) 512-5820
Toll Free (866) 345-0973



POLICY NUMBER :
9906-4867 1B

FOR HSR USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)		2. Social Security Number		3. Gender M F	4. Birthday	5. E-Mail
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)						
7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)						
8. Date and Time of Accident		9. Place where Accident Occurred			10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer	
Dental Claims	11. Indicate which Teeth were Involved in the Accident		12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)					Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident						
15. Did Accident Occur (Check Yes or No for Each of the Following):						
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?				<input type="checkbox"/> YES <input type="checkbox"/> NO		
B. On activity premises?				<input type="checkbox"/> YES <input type="checkbox"/> NO		
C. While traveling directly and uninterruptedly to or from home and policyholder premises?				<input type="checkbox"/> YES <input type="checkbox"/> NO		
D. During intercollegiate/scholastic athletic practice?				<input type="checkbox"/> YES <input type="checkbox"/> NO or competition? <input type="checkbox"/> YES <input type="checkbox"/> NO		
16. Team/League Name		17. Name of Event or Activity			18. Name and Title of Supervisor	
19. Name of Policyholder Chandler Youth Baseball		20. Address of Policyholder (Address, City, State, Zip) P.O.Box 6833 Chandler, AZ 85246				
21. Signature of Insurance Coordinator			22. Title of Insurance Coordinator		23. Date	

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES NO

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC., or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
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PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

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, Louisiana, Maryland, 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.

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.

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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: 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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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: 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 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 makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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.

GAGLIARDI INSURANCE SERVICES, INC.

284 Digital Drive, Morgan Hill, CA 95037 800-995-9768 Fax 408-414-8199

IMPORTANT INSTRUCTIONS

HOW TO FILE YOUR MEDICAL CLAIM

1. You have been provided with claim forms that are pre-filled with some of the important information that is needed to process your claim efficiently. Please use this form only.
2. Section I must be filled out completely.
3. Section II is to be completed, signed, and dated by the claimant or parent/guardian of the claimant.
4. Include all itemized bills for related medical expenses being claimed. These bills must show the patient's name, condition being treated (diagnosis), type of treatment received, date the expense(s) was/were incurred.
5. A deductible will apply to each claim.
6. A League Representative or Insurance Coordinator **must** sign Claim Form.

NOTE:

This coverage is in excess of all other group medical coverage. Please complete in full the attached **Other Insurance Inquiry** and provide copies of the other insurance's **Explanation of Benefits** for each corresponding **Itemized Bill**. Failure to provide this form, completed in its entirety, will delay claim processing.

Mail **FULLY COMPLETED** Claim Form to:
HSR Plaza II
4100 Medical Parkway
Carrollton TX 75007
Phone (972) 512-5600 Fax (972) 512-5820
Toll Free (866) 345-0973
E-Mail gisclaims@hsri.com

For questions, inquiries and/or status of your claim call (866) 345-0973