SOFTBALL BC

2011 REQUEST FOR OUT-OF-PROVINCE TRAVEL

(Required for Travel Medical Insurance)

Instructions:

Please complete the attached 2 pages of the Travel Permit Request and submit it to Lesley at Softball BC. You can fax to 604-531-8831 or email to info@softball.bc.ca. Please include a copy of your current roster.

Teams receive three (3) days per calendar free of charge. Teams traveling more than three days can obtain Travel Medical Insurance from Softball BC for a fee of $15.00 per team per day. Your team can also choose to purchase medical coverage elsewhere, but are still required to submit a travel permit request to the office. You can opt out of the coverage on page 3 of this request.

Please complete the following so that your Travel Permit can be emailed back to you:

Team Name:

Coaches Name:

Coach/Manager Email:

Contact Phone Number:

If you have any further questions or concerns, please contact Lesley at the Softball BC office.

Phone: 604-531-0044

Email: info@softball.bc.ca

Please submit requests no later than 5 working days prior to your event and include any and all travel days in your request, not just playing days.

Thank you.

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TRAVEL PERMIT REQUEST

DATE REQUESTED: _____

THIS TRAVEL REQUEST IS FOR:

_____
(Name of player, team, coach or umpire)

From the Municipality of: _____, British Columbia

This player, umpire, coach, and/or team would like permission to travel to:

_____
(City, Province/Territory and Country)

For the: _____
(Name & Type of Event)

From: _____

To_____
(Dates team, coach, umpire or player will be out of BC)

Purpose of Travel: _____
_____
_____

Provided all applicable rules, regulations, and fees of Softball BC and all other affiliated associations are strictly adhered to:
Signed by: _____ Title: Executive Director, Softball BC

Office Use Only:

*Travel Medical Insurance has been purchased through Softball BC ☐
*Travel Medical Insurance has been declined through Softball BC ☐

PO Box 45570, Sunnyside Mall
Surrey, B.C. V4A 9N3

Telephone: 604-531-0044
FAX: 604-531-8831

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Calculation of Travel Medical Insurance Coverage:

Number of travel days _____ X $15.00 per day/team = $ _____

Method of Payment

Credit Card ☐ ***Visa*** ☐ ***MasterCard***

Card Number

Expiry: Month/Year

Name as it appears on card: _____

☐ **CASH**

☐ **CHEQUE**

☐ **I decline the purchase of Travel Medical Insurance for the Player, Umpire, Coach or team listed above**

_____ _____

(Please print name) **Signature**

OFFICE USE ONLY:

DATE RECEIVED: _____AMOUNT: $ _____ CASH CHEQUE CREDIT CARD

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