



PARTICIPANT ACCIDENT INSURANCE CLAIM FORM

(NOTE To the Participant/Parent/Guardian: Report and Claim Form will be returned if not fully completed and signed.)

Basic Procedures for Submitting the Incident Report and Participant Accident Insurance Claim Form

1. The insurance coordinator, coach or league representative will complete the incident report (front). If the policy provides accident medical coverage and the injured party was an event participant, the form should be given to the participant or parents to complete the participant accident medical insurance claim form (Part II).
2. The participant or participant's parents/guardian will complete the form, detach it from the instruction page, and forward it to K&K Insurance Group, Inc.
3. IF CLAIM INVOLVES INJURY TO A SPECTATOR OR PROPERTY DAMAGE, ONLY THE INCIDENT REPORT NEED BE COMPLETED.

To the Participant/Parent/Guardian:

Attach current itemized physician, hospital, or other provider's bills for accident medical expenses being claimed as well as the primary carrier's Explanation of Benefits showing their payments and denials. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made.

MAIL TO:
K&K INSURANCE GROUP, INC.
Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917



1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
(800) 237-2917 Fax (312) 381-9077
email: KK_PAClaims@kandkinsurance.com
http://www.kandkinsurance.com

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> PROPERTY DAMAGE <input type="checkbox"/> OTHER: _____	
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT: _____ SPORT: _____ SANCTIONED BY: _____ LOCATION: _____	
HAPPENED TO	NAME: _____ AGE: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: () _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
FUNCTION	AS: <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> SPECTATOR <input type="checkbox"/> BYSTANDER <input type="checkbox"/> OFFICIAL <input type="checkbox"/> OTHER: _____	
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY	
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____	
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____ _____	
WITNESSES	NAME: _____ NAME: _____ ADDRESS: _____ ADDRESS: _____ PHONE: _____ PHONE: () _____	
INSURED	NAME OF INSURED: _____ POLICY#: _____ CLUB NAME: _____ CITY/STATE: _____	
COACH/OFFICIAL/ TEAM OR LEAGUE REPRESENTATIVE	NAME: _____ PHONE: () _____ TITLE: _____ ORGANIZATION: _____ SIGNATURE: _____ DATE: _____	

COMPLETE ALL SECTIONS AND FAX TO (312) 381-9077, email: KK_PAClaims@kandkinsurance.com
OR MAIL IMMEDIATELY TO:

K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE
BEFORE RETURNING OR PROCESSING MAY BE DELAYED

ACCIDENT MEDICAL INSURANCE CLAIM FORM

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS
CLAIM FORM BE FURNISHED.

OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER HEALTH & ACCIDENT INSURANCE AVAILABLE. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL. IF THERE IS NO OTHER INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. NOTE: COVERAGE MAY ALSO INCLUDE A POLICY DEDUCTIBLE.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM

INJURED PERSON: _____	SPOUSE'S NAME (if applicable): _____
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
EMPLOYER NAME: _____	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: () _____	PHONE: () _____
GROUP INSURANCE COMPANY: _____	GROUP INSURANCE COMPANY: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COMPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
SOCIAL SECURITY NUMBER: _____	SOCIAL SECURITY NUMBER: _____
SIGNATURE: _____	SIGNATURE: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: _____ DATE: _____

Applicable in 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.

Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington and West Virginia

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, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied.

Applicable in 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Applicable in Florida and Idaho

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.*

* In Florida - Third Degree Felony

Applicable in 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.

Applicable in 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.

Applicable in Minnesota

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

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with 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.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she 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.

Applicable in 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.

Dear Participant: If you have an appointment with a doctor as the result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates:



INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT /GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.