K&K INSURANCE

Accident Report and Accident Insurance Claim Form

(NOTE: Report and Claim Form will be returned if not fully completed and signed.)

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

1. **A coach or league official will complete and sign the case 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 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 ACCIDENT REPORT NEED BE COMPLETED.**

To the Participant/Parent/Guardian:

YOUR CLAIM MUST BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN PROCESSED, 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.

K&K INSURANCE GROUP, INC.

Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917

(Please check and/or circle one per section, and complete relevant blanks.)

USSSA CASE REPORT

K&K INSURANCE

SPECIALTY BENEFITS, INC.
an affiliate of K&K Insurance Group, Inc.

1712 Magnavox Way, P.O. Box 2338
Fort Wayne, Indiana 46801-2338
Phone: 800-237-2917
Fax (260) 459-5915

ON BEHALF OF NATIONWIDE INSURANCE

Name:_____ Phone: (_____)_____
Address:_____
City:_____ State:_____ Zip:_____
Age:_____ Sex: (M) (F) Soc. Sec. #:_____
Years' Experience: (1st) (1-3) (4-9) (10+)
Team Name:_____
League Name:_____

SITE IF NOT TEAM/LOCATION:_____
CONTACT PERSON:_____ Phone:(_____)_____

Injury: ☐ Person ☐ Property
Date of Injury:_____ ☐ Morning ☐ Afternoon ☐ Evening ☐ Lights
Body Part Injured:_____ ☐ Left ☐ Right ☐ Both ☐ N/A
Estimated Absence from Playing: ☐ 1-7 days ☐ 1-3 weeks ☐ 3+ weeks ☐ Fatality
Disposition: ☐ On-Site Care Only ☐ Ambulance to_____ City:_____
Condition (Laceration, Concussion, Sprain, Fracture, etc.):_____
Does player have other insurance? ☐ Yes ☐ No If yes, company:_____

SPORT PROGRAM:
☐ Baseball ☐ Flag/Touch Football
☐ Basketball ☐ Softball
☐ Soccer ☐ Volleyball
☐ Other:_____

OCCASION:
☐ To/From Game ☐ To/From Practice
☐ Warmups ☐ During Game:
☐ Between Innings (_____ Inning)
☐ Practice: (Early) (Mid) (Late)
☐ Practice Game Conditions

SITUATION:
☐ Hit By:_____
☐ Hit:_____
☐ Fall: (Slip) (Trip) (Pushed)
☐ Non-Contact Injury
☐ Other:_____

LOCATION:
☐ Court/Links/Field
☐ Spectator Area
☐ Sport Facility/Other
(Locker Room) (Walkway)
☐ Parking Area
☐ Street/Road
☐ Other:_____

SURFACE INVOLVED:
☐ Grass ☐ Dirt
☐ Artificial ☐ Brick
☐ Wood ☐ Metal
☐ Other:_____

DESCRIBE HOW ACCIDENT HAPPENED:
_____
_____
_____
_____

ACTIVITY:
☐ While Participating
☐ Training/Exercising
☐ Observing
☐ Non-Sport Routine
☐ Altercation
☐ Game
☐ Other:_____

SPECIAL CIRCUMSTANCES:
☐ Not Applicable
☐ Protective Equipment Not Worn
☐ Despite Protective Equipment
☐ Rule Infraction: (Injured) (Another)
☐ Facility Related: (Explain)
_____
_____
☐ Other:_____
_____
_____

THIS PORTION MUST BE COMPLETED IN ITS ENTIRETY BY A COACH OR LEAGUE OFFICIAL

Signature of Coach or League Official:_____

Print Name of Coach or League Official:_____Phone # (_____)_____

Address:_____ City:_____ State:_____ Zip:_____

Return completed form to: K&K Insurance Group, Inc. / Specialty Benefits
Claims Department, PO Box 2338, Fort Wayne, IN 46801-2338
(800) 237-2917 • Fax (260) 459-5915

ACCIDENT INSURANCE CLAIM FORM

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE COMPLETED. OMISSION OF ANY OF THIS INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

PART II - PLEASE READ INSTRUCTIONS

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER INSURANCE. YOUR CLAIM MUST BE SUBMITTED TO YOUR PRIMARY INSURANCE CARRIER THAT INCLUDES A PERSONAL, EMPLOYERS OR GOVERNMENTAL HEALTH PLAN. AFTER PRIMARY INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE PRIMARY INSURANCE COMPANY'S EXPLANATION OF BENEFITS FORM.

IF YOUR PRIMARY INSURANCE CARRIER DENIES BENEFITS, SEND A COPY OF THE DENIAL ALONG WITH YOUR ITEMIZED MEDICAL BILLS. THESE MEDICAL BILLS MUST INDICATE THE PATIENTS NAME, CONDITION, TYPE OF TREATMENT, DATE THE EXPENSE OCCURRED AND CHARGES MADE. DEDUCTIBLES WILL BE IMPOSED DEPENDING ON THE COVERAGE DESCRIPTION.

TO BE COMPLETED BY INJURED PERSON OR PARENT

Minor Injured Party: _____

(Please complete following "other insurance" section for each parent/guardian.)

Injured Person: _____

Employer Name: _____

Employer Address: _____

City: _____ St: _____ Zip _____

Phone: ( )_____ Policy #: _____

Group Insurance Company:_____

Ins. Co. Address: _____

City: _____ St: _____ Zip _____

Social Security Number: _____

Signature:_____ Date: _____

Adult Injured Party: _____

(Please complete following "other insurance" section for yourself as well as spouse.)

Parent or Spouse Name: _____

Employer Name: _____

Employer Address: _____

City: _____ St: _____ Zip _____

Phone: ( )_____ Policy #: _____

Group Insurance Company:_____

Ins. Co. Address: _____

City: _____ St: _____ Zip _____

Social Security Number: _____

Signature:_____ Date: _____

(Tear off and send as instructed)

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVE 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 PROPER INFORMATION NEEDED TO PROCESS MY CLAIM.

_____ _____

Signed **Date**

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

Return completed form to: K&K Insurance Group, Inc. / Specialty Benefits
Claims Department, PO Box 2338, Fort Wayne, IN 46801-2338

1354 12/05

Arkansas, Florida, Kentucky, Michigan, New Jersey and Pennsylvania
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 civil penalties.

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. California Insurance Frauds Prevention Act 1871.2

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 a insurance company who knowingly provides false, incomplete, or misleading facts or information to a 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.

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, this is a third degree felony.

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.

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

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.

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.

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 or 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
Any person who knowingly & 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. (360.S. 5361.1)

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:

The First Health Network

HYGEIA

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.