



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

AMATEUR SPORTS ACCIDENT INSURANCE CLAIM FORM

PROOF OF LOSS • TO BE COMPLETED BY PARTICIPANT OR PARENT

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THE CLAIM FORM BE PROVIDED. OMISSION OF VITAL INFORMATION WILL RESULT IN DELAYS IN CLAIM PROCESSING.

NAME OF INJURED PERSON _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____
Street City State Zip Home Work

DATE INJURY OCCURRED _____ SPORT COVERED _____
Month / Day / Year

LOCATION & DESCRIPTION OF HOW INJURY OCCURRED _____

PART OF BODY INJURED _____

COVERAGE UNDER THIS SPORTS POLICY IS EXCESS OVER ALL OTHER INSURANCE. THIS MEANS THAT YOUR CLAIM FOR INJURY SHOULD FIRST BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR PERSONAL HEALTH PLAN, YOUR EMPLOYER, YOUR SPOUSE'S EMPLOYER OR THROUGH SOME GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCES HAVE PAID THEIR BENEFITS, YOU SHOULD NOTIFY US OF BENEFITS PAID. IF YOU BELIEVE YOUR OTHER COVERAGE WILL NOT PROVIDE BENEFITS, SEND US A COPY OF ITEMIZED CHARGES AND PROOF OF DENIAL AND/OR PAYMENT. COVERED EXPENSES ARE SUBJECT TO \$100 PER CLAIM DEDUCTIBLE. ONLY EXPENSES INCURRED WITHIN 104 WEEKS FROM THE DATE OF THE ACCIDENT WILL BE CONSIDERED.

WE WILL BE UNABLE TO PROCESS YOUR CLAIM WITHOUT THE EMPLOYER INFORMATION, EVEN THOUGH YOU MAY BELIEVE THERE IS NO OTHER COVERAGE. THE DATA REQUESTED IS IMPERATIVE AND WILL EXPEDITE YOUR CLAIM PROCESSING.

MOTHER/INJURED PERSON _____

FATHER/SPOUSE _____

EMPLOYER NAME _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

EMPLOYER ADDRESS _____

PHONE _____ POLICY NO. _____

PHONE _____ POLICY NO. _____

GROUP INSURANCE COMPANY _____

GROUP INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY ADDRESS _____

SOCIAL SECURITY NUMBER _____

SOCIAL SECURITY NUMBER _____

- YES — CLAIMANT IS COVERED BY THIS POLICY
- NO — CLAIMANT IS NOT COVERED BY THIS POLICY

- YES — CLAIMANT IS COVERED BY THIS POLICY
- NO — CLAIMANT IS NOT COVERED BY THIS POLICY

AUTHORIZATION

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K CLAIM SERVICE 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 CLAIM SERVICE 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 PHOTO COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

(THE ABOVE PARAGRAPHS ARE BEING USED IN ORDER TO FACILITATE OUR OBTAINING AND PROVIDING PROPER INFORMATION NEEDED TO QUICKLY PROCESS YOUR CLAIM.)

I CERTIFY THAT ALL THE FOREGOING STATEMENTS AND ANSWERS ON THIS FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE _____

DATE _____

PLEASE NOTE: IF INJURED PERSON IS A MINOR, SIGNATURE MUST BE OF PARENT OR LEGAL GUARDIAN.

TO BE COMPLETED BY SPORTS PROGRAM INSURANCE COORDINATOR

SPORTS PROGRAM REPRESENTATIVE'S CERTIFICATION

I hereby certify that the person named below was insured for the activity in which the injury occurred and that the premium was paid prior to the date of injury.

FULL NAME OF SPORTS ORGANIZATION _____ POLICY NUMBER _____

MAILING ADDRESS _____ PHONE _____
Street City State Zip

PRINTED NAME OF OFFICIAL _____ AUTHORIZED SIGNATURE _____ DATE _____

Dear Sports Participant: If you have treatment as the result of an injury sustained while participating in a covered event, 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:



BEECH STREET CORPORATION

AMERICA'S HEALTH PLAN
DIMENSION
FIRST CHOICE
HEALTH CHOICE
MANAGED HEALTHCARE NW
MOUNTAIN MEDICAL AFFILIATES
PREFERRED HEALTH PARTNERSHIP
PREMIER PREFERRED CARE
PRO-NET
SOUTHEAST MED. ALLIANCE



MULTIPLAN



MEDICAL RESOURCE

ETHIX
HEALTH CARE PREFERRED
HEALTH CARE SAVINGS
HEALTH NETWORK
INTERGROUP
MULTIPLAN
PREFERRED HEALTH PLAN
PREFERRED PLANS, INC
PRIMARY HEALTH SERVICES
SOONER HEALTH
VIRGINIA HEALTH NETWORK

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 an 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.

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 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. (360.S. 5361.1)