



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

PARTICIPANT ACCIDENT MEDICAL INSURANCE CLAIM FORM INSTRUCTIONS



National Federation of
State High School
Associations

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

Basic Procedures for Submitting the Accident Claim Form

1. The injured official will complete Parts I & II.
2. Have Part I signed by the game assigner. Part II needs to be signed by the injured official and forward both forms to K&K Insurance Group, Inc./Specialty Benefits, Inc. at the address below.

To the Injured Official:

Give the medical providers involved in your care, the contact information below for billing. This policy provides excess/secondary coverage, so if you have other insurance, advise the medical providers that the other insurance is primary and this policy is secondary. By giving them this information, we will be billed with the proper billing forms and your primary insurance Explanation of Benefits.

MAIL TO:

K&K INSURANCE GROUP, INC./SPECIALTY BENEFITS, INC.

Claims Department

P.O. Box 2338

Fort Wayne, Indiana 46801-2338

Phone:(800) 237-2917

Fax:(312) 381-9077

Email: KK.PAClaims@kandkinsurance.com



**SPECIALTY
BENEFITS, INC.**
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Hartford Life & Accident Insurance Company
ACCIDENT CLAIM FORM



National Federation of
State High School
Associations

CLAIMS DEPARTMENT

1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 | Fax: 312-381-9077 California License #0334819
email: KK.PAClaims@kandkinsurance.com
www.kandkinsurance.com

PART I
(PLEASE PRINT)

| | |
|-------------------------------------|---|
| NATURE | <input type="checkbox"/> BODILY INJURY <input type="checkbox"/> OTHER: _____ |
| TIME & PLACE OF INCIDENT | DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT TYPE: _____ LOCATION: _____ |
| HAPPENED TO | NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: (____) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ E-MAIL ADDRESS: _____ |
| 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 (If known) | NAME: _____ NAME: _____ ADDRESS: _____ ADDRESS: _____ PHONE: (____) _____ PHONE: (____) _____ |
| INSURED | NAME OF INSURED: <u>National Federation of State High School Officials (NFHS)</u> |
| GAME ASSIGNER | NAME: _____ PHONE: (____) _____ TITLE: _____ ORGANIZATION: _____ <i>I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.</i> SIGNATURE: _____ DATE: _____ E-MAIL ADDRESS: _____ |

— PER POLICY PROVISIONS HEAT EXHAUSTION AND DEHYDRATION ARE NOT COVERED —
COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:
K&K INSURANCE GROUP, INC./SPECIALTY BENEFITS INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338
THIS FORM MUST INCLUDE THE SIGNATURE OF THE INSURED/REPRESENTATIVE
BEFORE RETURNING OR PROCESSING MAY BE DELAYED



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

PARTICIPANT ACCIDENT MEDICAL INSURANCE CLAIM FORM

Insured Name: NFHS (National Federation of State High School Officials)
 Injured Official: _____

**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 OFFICIAL PART II

MEDICAL BENEFITS UNDER THIS POLICY WILL PROVIDE EXCESS COVERAGE. UPON RECEIPT OF THIS CLAIM FORM, AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN 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.

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.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNED: _____ DATE: _____

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

FRAUD WARNING CERTIFICATION

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of 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.

For Residents of 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee and Washington: 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 and denial of insurance benefits.

For residents of Virginia: Any person who, with the 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 may have violated the state law.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

REV 08/2016

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution

Signature of Parent/Guardian or Adult Claimant

Date

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./Specialty Benefits, 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.