Basic Procedures for Submitting Case Report and Accident Insurance Claim Form

1. The participant or participant’s parent/guardian should complete pages 2 and 3 of the form, and forward it to K&K Insurance Group, Inc.
2. The coach/program administrator must sign the completed case report.
3. If referee claim, the Referee in Chief must sign the completed case report.

To the Athlete/Parent/Guardian/Coach/Referee/Volunteer

Attach current itemized physician, hospital or other provider’s bills for accident medical expenses claimed as well as the primary carrier’s explanation of benefits showing 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.

K&K INSURANCE GROUP, INC. / SPECIALTY BENEFITS, INC.
Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917

Instructions for Completing the Accident Insurance Form to the Injured Person/Parent/Guardian

To the injured person/parent/guardian: 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.

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 guilty of a crime and 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.
USA Hockey Case Report
For registered Players/Coaches/Referees/Volunteers

INJURY:
Date of Injury:
Body part injured:
Describe nature of injury (fracture, contusion, concussion, paralysis, dislocation, sprain, etc.):

LOCATION:

OCCASION:
Home Game
Away Game
(To) (From) Game
Warm-ups (Before Game)
During Game (_____ Period)
Between Periods
After Game
During Practice
_____ Early
_____ Mid
_____ Late
Practice/Scrimmage
Other:

BOARD CONDITION:
Plastic
Plywood
Temporary
Other:

PROTECTION ABOVE BOARDS:
None
Glass
Netting
Wire
Other:

LIFE OF PLAY:
14 & Under
16 & Under
18 & Under
12 & Under
Adult
Type of Team:
Youth
Girls/Women
Junior A, B, C
Major Jr / Tier 1
Adult
Other:

Program Name:
Rink Name:
City/State:

INJURED:
(Player) (Referee) (Coach) Other:
Name:
Birthdate:
Gender: (M) (F)
Address:
Phone:
City:
State:
Zip:
Team Name:

TIME:
Morning
Afternoon
Evening
After Hours
Ambulance
Car
Refused Care

DISPOSITION:
On-Site Care Only
Hospital by:

WITNESSES:
Name:
Phone:
Name:
Phone:

FACE PROTECTION:
Full Facemask
None
Half Shield
Knocked Off

POSITION:
Center
Wing
Forward
Defense

PENALTY:
Was a penalty called? Yes No
Penalty call on:
Opponent
Injured Player

SURFACE CONDITION:

DESCRIPTION HOW ACCIDENT HAPPENED:
(Be specific.)

NON-REFEREE INJURIES
I verify that this injury occurred during a USA Hockey sanctioned “event”.
Coach/Program Administrator (Print name):
(Signature):__________ Phone: (______) Date:__________

REFEREE INJURIES
REFEREE CLAIMS MUST BE MAILED TO DISTRICT REFEREE IN CHIEF FOR VERIFICATION AND SIGNATURE
USA Hockey District:
Registration Level: 1 2 3 4
Was the above referee a registered official at the time of injury? Yes No
Did this injury occur during a USA Hockey sanctioned event? Yes No
Signature of District Referee in Chief:
Date:__________

PLEASE REMEMBER
1. You must return this form to: USA Hockey, c/o K&K Insurance Group – Claims Dept., 1712 Magnavox Way, P.O. Box 2338, Fort Wayne, IN 46801-2338.
2. Do NOT take this form to your medical provider for completion: YOU MUST FILL IT OUT.
3. You and your COACH/PROGRAM ADMINISTRATOR MUST SIGN this form.
4. We MUST have a copy of your USA Hockey Individual membership card, IMR form, or USA Hockey roster to process your claim.
5. USA Hockey Insurance is an excess policy and may carry a DEDUCTIBLE.
6. Keep a copy for your files.

(Mark all that apply. Complete relevant blanks.)

NON-REFEREE INJURIES
I verify that this injury occurred during a USA Hockey sanctioned “event”.
Coach/Program Administrator (Print name):
(Signature):__________ Phone: (______) Date:__________

REFEREE INJURIES
REFEREE CLAIMS MUST BE MAILED TO DISTRICT REFEREE IN CHIEF FOR VERIFICATION AND SIGNATURE
USA Hockey District:
Registration Level: 1 2 3 4
Was the above referee a registered official at the time of injury? Yes No
Did this injury occur during a USA Hockey sanctioned event? Yes No
Signature of District Referee in Chief:
Date:__________

ON BEHALF OF NATIONWIDE INSURANCE
1712 Magnavox Way, P.O. Box 2338
Fort Wayne, Indiana 46801-2338
Phone: 800-237-2917
Fax (260) 459-5915
1257 HC-1 REV. 4/07
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Please note: If Injured Person is a Minor, we must have both parents' information. If the injured person is married, we must have the spouse's information or mark area N/A.

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

TO BE COMPLETED BY INJURED PERSON OR PARENT

Coverage under the policy is excess over all other valid and collectible health and accident plans. Your claim should be submitted to the insurance company providing coverage to you through your own, your parents' or your spouse's 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 valid and collectible insurance, this policy will act as primary insurance. Further details of coverage will be communicated to you upon receipt of this fully completed claim form.

We will not process your claim without employer information. The data requested is imperative and will expedite your claim processing.

Insured Person's Name: ___________________________ Spouse's Name (if applicable): ___________________________

Father's Name (if minor): ___________________________ Mother's Name (if minor): ___________________________

Social Security No.: ___________________________ Social Security No.: ___________________________

Employer's Name: ___________________________ Employer's Name: ___________________________

Employer's Address: ___________________________ Employer's Address: ___________________________


Phone: ___________________________ Policy No.: ___________________________ Phone: ___________________________ Policy No.: ___________________________

Group Insurance Company: ___________________________ Group Insurance Company: ___________________________

Insurance Company's Address: ___________________________ Insurance Company's Address: ___________________________


I certify that this injury occurred to a USA Hockey registered member during a USA Hockey sanctioned activity (supervised game/practice, not pickup hockey), the above information is true and accurate to the best of my knowledge and belief, and I understand fraudulent statements can be a crime.

Signature: ___________________________ Date: ___________________________

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc., Specialty Benefits, Inc. or its representatives to furnish to any hospital, physician or other person who has attended me, and my primary 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 primary 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 quickly process my claim.

Signature: ___________________________ Date: ___________________________

Please note: If Injured Person is a Minor, signature must be of Parent or Legal Guardian.