Policy # SRPO0000018331101

000343678 / SRPO0000018331101

K&K INSURANCE

Group Accident Claims
1712 Magnavox Way P.O. Box 2338
Fort Wayne, IN 46801
PH (800) 237-2917
Fax: (312) 381-9077
http://www.kandkinsurance.com
KK.PAClaims@kandkinsurance.com

AXIS

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE
O BODILY INJURY O PROPERTY DAMAGE O OTHER: _____

TIME & PLACE OF INCIDENT
DATE: _____ TIME: _____ O AM O PM
EVENT NAME: _____
EVENT TYPE: _____ SANCTIONED BY: _____
LOCATION: _____

HAPPENED TO
NAME: _____ SSN: _____
DATE OF BIRTH: _____ SEX: O Male O Female PHONE: ( ) _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
EMAIL ADDRESS: _____

FUNCTION
AS: O ATHLETE O PARTICIPANT O VOLUNTEER O SPECTATOR O BYSTANDER
O OFFICIAL O OTHER: _____

APPARENT INJURY OR DAMAGE
BODY PART: _____
CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____
O ON SITE CARE ONLY, BY O PHYSICIAN O EMT O TRAINER O OTHER: _____
O AMBULANCE, TAKEN TO: _____ CITY: _____
O FATALITY: _____

OCCASION
WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____

INCIDENT DESCRIP-TION
DESCRIBE WHAT HAPPENED: _____

WITNESSES (If known)
NAME: _____ NAME: _____
ADDRESS: _____ ADDRESS: _____
PHONE: ( ) _____ PHONE: ( ) _____

INSURED
NAME OF INSURED: _____ POLICY#: _____
CLUB NAME: _____ PHONE: _____
CITY: _____ STATE: _____

INSURED REPRESENT-ATIVE
O COACH O OFFICIAL O TRAINER O PROMOTER O TEAM/LEAGUE REPRESENTATIVE
O OTHER: _____
NAME: _____ PHONE: ( ) _____
TITLE: _____ ORGANIZATION: _____
SIGNATURE: _____ DATE: _____

COMPLETE ALL SECTIONS AND FAX 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.

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AXIS

PARTICIPANT ACCIDENT OTHER INSURANCE FORM

Insured Name: _____

Policy Number: _____

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

MEDICAL BENEFITS UNDER THIS POLICY MAY PROVIDE PRIMARY, EXCESS OR A COMBINATION OF BOTH COVERAGES. UPON RECEIPT OF THIS CLAIM FORM, AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

IF THE MEDICAL BENEFIT IS EXCESS, 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 BENEFIT, SEND A COPY OF THEIR DENIAL.

WE WILL NOT PROCESS YOUR CLAIM WITHOUTH 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:** _____

DATE OF BIRTH: _____ **DATE OF BIRTH:** _____

SIGNATURE: _____ **SIGNATURE:** _____

QUESTIONS REGARDING INCOME ARE ONLY APPLICABLE IF POLICY AFFORDS WEEKLY INDEMNITY BENEFITS.

REGULAR WEEKLY INCOME: _____ **INCOME LOST PER WEEK DUE TO INJURY:** _____

ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME WORK? _____ **ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME RACING AND/OR PARTICIPATE IN A RACING EVENT?** _____

I WAIVE ANY PROVISION OF THE 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 AND 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: _____

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

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PARTICIPANT ACCIDENT INSURANCE CLAIM FORM INSTRUCTIONS

(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, official, trainer, promoter 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.
Group Accident Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917
Fax: (312) 381-9077
Email: kk.paclaims@kandkinsurance.com

IMPORTANT NOTICE

• **In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:** 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 Alabama:** Any person who knowingly present 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 restitution fines and confinement in prison, or any combination thereof.

• **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 or award payable from Insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

• **For residents of the District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

• **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 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 include imprisonment, fines and denial of insurance benefits.

• **For residents of Oregon:** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.

• **For residents of Maryland:** Any person who knowingly of 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.

• **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

• **For residents of New Mexico:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

• **For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files and 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 Ohio:** Any person who, with intent to defraud of knowing that he is facilitating a fraud against an Insurer, submits a false or deceptive statement is guilty of Insurance fraud.

• **For residents of 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.

• **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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

• **For residents of Texas:** Any person who knowingly presents a 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 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 false or deceptive statement may have violated state law.

[AXIS_FRAUD 0220]

Dear Participant: If you have an appointment with a doctor as a 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

PHCS

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.