



CASE REPORT AND ACCIDENT INSURANCE CLAIM FORM

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

SPECIALTY BENEFITS, INC.

an affiliate of K&K Insurance Group, Inc.

Basic Procedures for Submitting Case Report and Accident Insurance Claim Form

1. The participant or participant's parents/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.

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)



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

USA Hockey Case Report

For registered Players/Coaches/
 Referees/Volunteers



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.)

LEVEL OF PLAY: <input type="checkbox"/> 8 & Under <input type="checkbox"/> 14 & Under <input type="checkbox"/> Youth Team <input type="checkbox"/> 10 & Under <input type="checkbox"/> 17 & Under <input type="checkbox"/> Girls/Women Team <input type="checkbox"/> 12 & Under <input type="checkbox"/> Adult <input type="checkbox"/> Other: _____		<input type="checkbox"/> League Play <input type="checkbox"/> Playoff <input type="checkbox"/> Tournament <input type="checkbox"/> Practice <input type="checkbox"/> Scrimmage <input type="checkbox"/> Other: _____
Program Name: _____ Rink Name: _____ City/State: _____		
INJURED: (Player) (Referee) (Coach) Other: _____ Name: _____ Birthdate: ____/____/____ Gender: (M) (F) Address: _____ Phone: (____) _____ City: _____ State: _____ Zip: _____ Team Name: _____		

INJURY: Date of Injury: _____ Describe nature of injury in detail: _____ _____ _____	TIME: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> After Hours	DISPOSITION: <input type="checkbox"/> On-Site Care Only <input type="checkbox"/> Hospital by: _____ <input type="checkbox"/> Ambulance _____ Car <input type="checkbox"/> Refused Care
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OCCASION: <input type="checkbox"/> Home Game <input type="checkbox"/> Away Game <input type="checkbox"/> (To) (From) Game <input type="checkbox"/> Warm-ups (Before Game) <input type="checkbox"/> During Game (____ Period) <input type="checkbox"/> Between Periods <input type="checkbox"/> After Game <input type="checkbox"/> During Practice ____ Early ____ Mid ____ Late <input type="checkbox"/> Practice/Scrimmage Other: _____	LOCATION: <input type="checkbox"/> On Ice (Check box on illustration below.) ____ Defensive ____ Offensive <input type="checkbox"/> Locker Room <input type="checkbox"/> Spectator Seating <input type="checkbox"/> Parking Lot <input type="checkbox"/> Bench <input type="checkbox"/> Other: _____	WITNESSES: Name: _____ Phone: (____) _____ Name: _____ Phone: (____) _____
BOARD CONDITION: <input type="checkbox"/> Plastic <input type="checkbox"/> Poor (Old) <input type="checkbox"/> Plywood <input type="checkbox"/> Temporary <input type="checkbox"/> Other: _____	SOURCE OF INJURY: <input type="checkbox"/> Hit by Puck <input type="checkbox"/> Other Contact <input type="checkbox"/> Hit by Stick _____ Checked from Behind <input type="checkbox"/> Collided with _____ Pushed from Behind ____ Goal _____ Struck by Opponent ____ Boards _____ Tripped by Opponent ____ Opponent _____ High Sticking ____ Teammate _____ Speared/Slashed ____ Open Ice Check <input type="checkbox"/> Other: _____ <input type="checkbox"/> Non-Contact Injury	FACE PROTECTION: <input type="checkbox"/> Full Facemask <input type="checkbox"/> None <input type="checkbox"/> Half Shield <input type="checkbox"/> Knocked Off
PROTECTION ABOVE BOARDS: <input type="checkbox"/> None <input type="checkbox"/> Glass <input type="checkbox"/> Netting <input type="checkbox"/> Wire <input type="checkbox"/> Other: _____		POSITION: <input type="checkbox"/> Center <input type="checkbox"/> Wing <input type="checkbox"/> Goal <input type="checkbox"/> Forward <input type="checkbox"/> Defense
		PENALTY: Was a penalty called? <input type="checkbox"/> Yes <input type="checkbox"/> No Penalty call on: <input type="checkbox"/> Opponent <input type="checkbox"/> Injured Player
		SURFACE CONDITION: _____ _____

DESCRIBE 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: _____ Was the above referee a registered official at the time of injury? YES NO
 Registration Level: 1 2 3 4
 Signature of District Referee in Chief: _____ Date: _____



USA HOCKEY ACCIDENT MEDICAL INSURANCE CLAIM FORM

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: _____

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

Phone: _____ Policy No.: _____ Phone: _____ Policy No.: _____

Group Insurance Company: _____ Group Insurance Company: _____

Insurance Company's Address: _____ Insurance Company's Address: _____

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

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.