



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 _____
<input type="checkbox"/> YES — CLAIMANT IS COVERED BY THIS POLICY	<input type="checkbox"/> YES — CLAIMANT IS COVERED BY THIS POLICY
<input type="checkbox"/> NO — CLAIMANT IS NOT COVERED BY THIS POLICY	<input type="checkbox"/> 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 _____