



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

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



USSSA ACCIDENT INSURANCE CLAIM FORM

PLEASE READ INSTRUCTIONS

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER INSURANCE. YOUR CLAIM MUST BE SUBMITTED TO YOUR PRIMARY INSURANCE CARRIER THAT INCLUDES A PERSONAL, EMPLOYERS OR GOVERNMENTAL HEALTH PLAN. AFTER PRIMARY INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE PRIMARY INSURANCE COMPANY'S EXPLANATION OF BENEFITS FORM.

IF YOUR PRIMARY INSURANCE CARRIER DENIES BENEFITS, SEND A COPY OF THE DENIAL ALONG WITH YOUR ITEMIZED MEDICAL BILLS. THESE MEDICAL BILLS MUST INDICATE THE PATIENTS NAME, CONDITION, TYPE OF TREATMENT, DATE THE EXPENSE OCCURRED AND CHARGES MADE. DEDUCTIBLES WILL BE IMPOSED DEPENDING ON THE COVERAGE DESCRIPTION.

TO BE COMPLETED BY INJURED PERSON OR PARENT

Minor Injured Party: _____

(Please complete following "other insurance" section for each parent/guardian.)

Injured Person/or Parent: _____

Employer Name: _____

Employer Address: _____

City: _____ St: _____ Zip _____

Phone: () _____ Policy #: _____

Group Insurance Company: _____

Ins. Co. Address: _____

City: _____ St: _____ Zip _____

Social Security Number: _____

Signature: _____ Date: _____

Adult Injured Party: _____

(Please complete following "other insurance" section for yourself as well as spouse.)

Parent or Spouse Name: _____

Employer Name: _____

Employer Address: _____

City: _____ St: _____ Zip _____

Phone: () _____ Policy #: _____

Group Insurance Company: _____

Ins. Co. Address: _____

City: _____ St: _____ Zip _____

Social Security Number: _____

Signature: _____ Date: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K 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 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 PROCESS MY CLAIM.

Signed _____

Date _____

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

Return completed form to: **K&K Insurance Group, Inc. / Specialty Benefits
Claims Department, PO Box 2338, Fort Wayne, IN 46801-2338**

PLEASE ATTACH A COPY OF THE CERTIFICATE OF INSURANCE APPLICABLE TO THIS CLAIM.
 (Please check and/or circle one per section, and complete relevant blanks.)



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 ON BEHALF OF NATIONWIDE INSURANCE

Name: _____ Phone: (_____) _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Age: _____ Sex: (M) (F) Date of Birth: _____
 Years' Experience: (1st) (1-3) (4-9) (10+)
 Team Name: _____
 USSSA Registration Number: _____

SITE IF NOT TEAM/LOCATION: _____
 CONTACT PERSON: _____ Phone: (_____) _____

Injury: Person Property Injured: Player Coach Umpire/Referee Volunteer
 Date of Injury: _____ Morning Afternoon Evening Lights
 Body Part Injured: _____ Left Right Both N/A
 Estimated Absence from Playing: _____ 1-7 days 1-3 weeks 3+ weeks Fatality
 Disposition: On-Site Care Only Ambulance to _____ City: _____
 Condition (Laceration, Concussion, Sprain, Fracture, etc.): _____
 Does player have other insurance? Yes No If yes, company: _____

<p>SPORT PROGRAM:</p> <input type="checkbox"/> Baseball <input type="checkbox"/> Flag/Touch Football <input type="checkbox"/> Basketball <input type="checkbox"/> Softball <input type="checkbox"/> Soccer <input type="checkbox"/> Volleyball <input type="checkbox"/> Other: _____	<p>LOCATION:</p> <input type="checkbox"/> Court/Links/Field <input type="checkbox"/> Spectator Area <input type="checkbox"/> Sport Facility/Other (Locker Room) (Walkway) <input type="checkbox"/> Parking Area <input type="checkbox"/> Street/Road <input type="checkbox"/> Other: _____	<p>ACTIVITY:</p> <input type="checkbox"/> While Participating <input type="checkbox"/> Training/Exercising <input type="checkbox"/> Observing <input type="checkbox"/> Non-Sport Routine <input type="checkbox"/> Altercation <input type="checkbox"/> Game <input type="checkbox"/> Other: _____
<p>OCCASION:</p> <input type="checkbox"/> To/From Game <input type="checkbox"/> To/From Practice <input type="checkbox"/> Warmups <input type="checkbox"/> During Game: <input type="checkbox"/> Between Innings (_____ Inning) <input type="checkbox"/> Practice: (Early) (Mid) (Late) <input type="checkbox"/> Practice Game Conditions	<p>SURFACE INVOLVED:</p> <input type="checkbox"/> Grass <input type="checkbox"/> Dirt <input type="checkbox"/> Artificial <input type="checkbox"/> Brick <input type="checkbox"/> Wood <input type="checkbox"/> Metal <input type="checkbox"/> Other: _____	<p>SPECIAL CIRCUMSTANCES:</p> <input type="checkbox"/> Not Applicable <input type="checkbox"/> Protective Equipment Not Worn <input type="checkbox"/> Despite Protective Equipment <input type="checkbox"/> Rule Infraction: (Injured) (Another) <input type="checkbox"/> Facility Related: (Explain) _____ _____ <input type="checkbox"/> Other: _____ _____ _____
<p>SITUATION:</p> <input type="checkbox"/> Hit By: _____ <input type="checkbox"/> Hit: _____ <input type="checkbox"/> Fall: (Slip) (Trip) (Pushed) <input type="checkbox"/> Non-Contact Injury <input type="checkbox"/> Other: _____	<p>DESCRIBE HOW ACCIDENT HAPPENED:</p> _____ _____ _____	

THIS PORTION MUST BE COMPLETED IN ITS ENTIRETY BY A COACH OR LEAGUE OFFICIAL

Signature of Coach or League Official: _____
 Print Name of Coach or League Official: _____ Phone # (_____) _____
 Address: _____ City: _____ State: _____ Zip: _____

Return completed form to: K&K Insurance Group, Inc. / Specialty Benefits Claims Department, PO Box 2338, Fort Wayne, IN 46801-2338
PLEASE ALLOW 15 BUSINESS DAYS FOR PROCESSING
 (800) 237-2917 • Fax (260) 459-5915

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 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.

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. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.



INSTRUCTIONS FOR USSSA Case Report and USSSA Accident Insurance Claim Form

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

Basic Procedures for Submitting the Accident Report and Accident Insurance Claim Form

1. The insurance coordinator, coach or league representative will complete the USSSA Case Report (front). The injured umpire will complete if the claim is on an umpire. The form should be given to the participant or parents to complete the USSSA Accident Medical insurance claim form.
2. Please attach a copy of the team, league or tournament Certificate of Insurance applicable to this claim before giving the form to the participant or parent.
3. Please read the information on the USSSA accident insurance claim form to be aware of plan requirements and limitations.
4. IF CLAIM INVOLVES INJURY TO A SPECTATOR OR PROPERTY DAMAGE, ONLY THE USSSA CASE REPORT NEED BE COMPLETED.
5. Upon receipt of this fully completed claim form, an acknowledgement/coverage letter will be sent.
6. We will require both parents employer/insurance information on the Accident Insurance Claim Form if the injured person is a minor.

To the Participant/Parent/Guardian:

- A). Provide all medical providers with your primary insurance information AND this information as secondary insurance through USSSA. If this is done, the medical providers will automatically bill K&K Insurance after the charges have been processed by the primary insurance.
- B). Only itemized medical bills showing diagnosis, treatment rendered and date of service will be accepted.
- C). If the USSSA plan is being used as a secondary insurance, all the medical bills must be accompanied by the primary insurance Explanation of Benefits(EOB).

K&K INSURANCE GROUP, INC.

Claims Department

P.O. Box 2338

Fort Wayne, Indiana 46801-2338

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PLEASE ALLOW 15 BUSINESS DAYS FOR PROCESSING



SPORTS PROVIDER ACCIDENT/INCIDENT REPORT FORM

GENERAL INFORMATION (Please, Print All Information):

_____ **Name Of Park** _____ **Date & Time Of Accident/Incident** _____ **Weather Conditions**

INJURED PARTICIPANT:

_____ **Name of Injured Person** _____ **Age** _____ **Phone**
 _____ **Address** _____ **City** _____ **State** _____ **Zip Code**

Employed By: _____

Describe Accident and the Injury: _____

FIRST AID:

Was First Aid Necessary? Yes No **What First Aid Was Provided?** _____

Who Administered First Aid: _____

Was Injured Person Transported To Hospital or other Medical Facility? Yes No

If Yes, Provide Details: _____

WITNESSES:

_____ **Name** _____ **Address**
 _____ **Name** _____ **Address**
 _____ **Name** _____ **Address**

PREVENTION:

In your opinion, what could have been done to prevent a similar accident/incident from happening in the future?

_____ **NAME OF PERSON COMPLETING REPORT** _____ **HOME/CELL TELEPHONE** _____ **WORK/CELL TELEPHONE**