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

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph:800-237-2917 | Fax: 312-381-9077 California License #0334819
email: kk.PAClaims@kandkinsurance.com
www.kandkinsurance.com

STUDENT OR ATHLETE ACCIDENT CLAIM FORM
Excess Coverage
K-12 ACCOUNTS

INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.

2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Student's Name Last: _____ First: _____ MI: _____
2. Date of Birth: _____ SS# _____ Sex: ☐ Male ☐ Female
3. Student's grade in school: _____
4. Home Address Street: _____
   City: _____ State: _____ Zip: _____
   Parent(s)/Guardian(s) Home Phone: _____
5. Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM
   Nature of Injury: _____ Describe exactly how accident happened: _____
   _____
6. Nature of activity and location during which the injury occurred (check all boxes which apply):

   ☐ Pre-Kindergarten ☐ Elementary School ☐ Middle School
   ☐ High School ☐ Cafeteria ☐ Classroom Activities
   ☐ Interscholastic Sports ☐ Intramural Sports, *name of sport, if applicable*: _____
   ☐ Club Sports ☐ Physical Education Class ☐ Other Activity (specify) _____
   ☐ During Practice ☐ During Play ☐ During Travel To or From the Event

   Nature of Your Participation:
   ☐ Student ☐ Volunteer ☐ Student/Manager
   ☐ Athletic Participant ☐ Cheerleader ☐ Band Member
   ☐ Other (specify) _____

7. Transfer Student? ☐ Yes ☐ No
   If yes, please identify the former school name: _____
8. Name, address and phone number of physician who first treated you: _____
   _____

9. Have you had a similar injury in the past? ☐ Yes ☐ No

If yes, describe and give dates: _____

10. Name, address and phone number of physician who treated you for previous injury: _____

_____

11. Are you covered by any other medical expense benefits plan? ☐ Yes ☐ No

If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

_____

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS *EXCESS* MEDICAL COVERAGE.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits and/or Zurich Insurance or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms 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.

Date _____ Parent/Guardian Signature _____

SECTION II – (TO BE COMPLETED BY PARTICIPATING SCHOOL)

FAILURE TO COMPLETE THIS FORM IN FULL
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Students Name: Last _____ First _____ MI _____
2. Date of Accident _____
3. Activity _____
4. Nature of Injury _____
5. Name of participating SCHOOL SYSTEM or SCHOOL DISTRICT Boone County
6. Name of participating SCHOOL Larry A Ryle High School
7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNATURE OF SCHOOL OFFICIAL: _____

PRINTED NAME/TITLE: Brad Bolte/ LAT

PHONE: (859) 301-9070 FAX: 859-384-5312

EMAIL: Brad.Bolte@stelizabeth.com DATE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms 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.

Date _____ Policyholder (School Official) Signature _____

TO BE COMPELTED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

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OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT O Yes O No

EMANCIPATED STUDENT: O Yes O No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: O Yes O No

NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
IS FATHER DECEASED? O Yes O No	IS MOTHER DECEASED? O Yes O No
IS FATHER LEGALLY RESPONSIBLE? O Yes O No	IS MOTHER LEGALLY RESPONSIBLE? O Yes O No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
SOCIAL SECURITY #: _____	SOCIAL SECURITY #: _____
EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No	EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No
EMPLOYER NAME: _____	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: (____) _____	PHONE: (____) _____
CONTACT PERSON: _____	CONTACT PERSON: _____
Do you have group medical insurance coverage through your employment? O Yes O No	Do you have group medical insurance coverage through your employment? O Yes O No
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)	TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)
O PREFERRED PROVIDER ORGANIZATION (PPO)	O PREFERRED PROVIDER ORGANIZATION (PPO)
O STANDARD MEDICAL AND HOSPITALIZATION COVERAGE	O STANDARD MEDICAL AND HOSPITALIZATION COVERAGES
O OTHER (describe) _____	O OTHER (describe _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: _____ PARENT/GUARDIAN/MOTHER SIGNATURE: _____

DATE: _____ DATE: _____