

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

Basic Procedures for Submitting Case Report and Accident Insurance Claim Form

1. The participant or participant's parents/guardian should complete page 2 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

Once the completed claim form has been submitted, forward 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. THESE DOCUMENTS MUST BE SUBMITTED WITHIN 15 MONTHS FROM THE ACCIDENT DATE IN ORDER TO BE ELIGIBLE FOR COVERAGE.

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.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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 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.

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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 a statement of claim or 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, Virginia 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 may include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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 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 Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefit and may be subject to civil penalties available.

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

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.



1712 Magnavox Way, P.O. Box 2338
 Fort Wayne, Indiana 46801-2338
 Phone: 800-237-2917 option 1, then 3
 Fax (312) 381-9077
 email: KK.PAClaims@kandkinsurance.com

USA Hockey Case Report

For registered Players/Coaches/ Referees/ Volunteers



PLEASE REMEMBER

- 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. Fax: 312-381-9077, email: KK.PAClaims@kandkinsurance.com
- Do **NOT** take this form to your medical provider for completion: **YOU MUST FILL IT OUT.**
- YOU and your COACH/PROGRAM ADMINISTRATOR **MUST SIGN** this form.
- Please submit this form to K&K Insurance immediately upon completion. Do not wait for medical bills. **The completed form, itemized bills and primary plan Explanation of Benefits must be submitted within 15 months from the date of the accident.**
- USA Hockey Insurance is an excess policy and members with primary insurance must meet a \$1,000 out-of-pocket expense obligation. Members with no primary insurance must meet a \$3,500 deductible. (Mark all that apply. Complete relevant blanks.)
- Keep a copy for your files.

LEVEL OF PLAY: <input type="checkbox"/> 8 & Under <input type="checkbox"/> 10 & Under <input type="checkbox"/> 12 & Under <input type="checkbox"/> 14 & Under <input type="checkbox"/> 16 & Under <input type="checkbox"/> 18 & Under <input type="checkbox"/> Adult	TYPE OF TEAM: <input type="checkbox"/> Youth <input type="checkbox"/> Girls/Women <input type="checkbox"/> Adult <input type="checkbox"/> Major Jr / Tier 1 <input type="checkbox"/> Junior A, B, C <input type="checkbox"/> Other _____	<input type="checkbox"/> League Play <input type="checkbox"/> Tournament <input type="checkbox"/> Practice <input type="checkbox"/> Other: _____
Program Name: _____ Rink Name: _____ City/State: _____		

INJURED: (Player) (Referee) (Coach) Other: _____

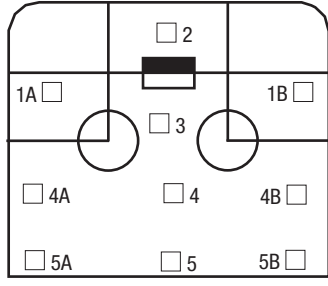
Name: _____ Birthdate: _____ Gender: (M) (F)
 Address: _____ Phone: (____) _____
 City: _____ State: _____ Zip: _____
 Team Name: _____
 If during a game, name of opposing team: _____

INJURY: Date of Injury: _____ Body part injured: _____
 Describe nature of injury (fracture, contusion, concussion, paralysis, dislocation, sprain, etc.): _____

TIME:
 Morning
 Afternoon
 Evening
 After Hours

DISPOSITION:
 On-Site Care Only
 Hospital by: _____ Ambulance _____ Car _____
 Refused Care

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: (____) _____
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BOARD CONDITION: <input type="checkbox"/> Plastic <input type="checkbox"/> Plywood <input type="checkbox"/> Other: _____ <input type="checkbox"/> Poor (Old) <input type="checkbox"/> Temporary	PROTECTION ABOVE BOARDS: <input type="checkbox"/> None <input type="checkbox"/> Netting <input type="checkbox"/> Other: _____ <input type="checkbox"/> Glass <input type="checkbox"/> Wire	SOURCE OF INJURY: <input type="checkbox"/> Hit by Puck <input type="checkbox"/> Hit by Stick <input type="checkbox"/> Collided with _____ Goal _____ Boards _____ Opponent _____ Teammate <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other Contact _____ Checked from Behind _____ Pushed from Behind _____ Struck by Opponent _____ Tripped by Opponent _____ High Sticking _____ Speared/Slashed _____ Open Ice Check <input type="checkbox"/> Non-Contact Injury	FACE PROTECTION: <input type="checkbox"/> Full Facemask <input type="checkbox"/> Half Shield <input type="checkbox"/> None <input type="checkbox"/> Knocked Off	POSITION: <input type="checkbox"/> Center <input type="checkbox"/> Forward <input type="checkbox"/> Wing <input type="checkbox"/> Defense <input type="checkbox"/> Goal	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: <input type="checkbox"/> Regular ice <input type="checkbox"/> Artificial ice
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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 Did this injury occur during a USA Hockey sanctioned event? YES NO
 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.

• Depending on the severity of your injury, would you mind being contacted by the USA Hockey Catastrophic Injury Registry for further information? Yes No

Signature: _____ Date: _____

PLEASE NOTE: If Injured Person is a Minor, signature must be of Parent or Legal Guardian.