1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
http://www.kandkinsurance.com

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE
❑ BODILY INJURY ❑ PROPERTY DAMAGE ❑ OTHER:______

TIME & PLACE OF INCIDENT
DATE:______ TIME:______ ❑ AM ❑ PM
EVENT NAME:______
EVENT TYPE:______ SANCTIONED BY:______
LOCATION:______

HAPPENED TO
NAME:______ SSN:______
DATE OF BIRTH: ______ SEX: ❑ Male ❑ Female PHONE: (   )______
ADDRESS:______
CITY:______ STATE:______ ZIP:______

FUNCTION
AS: ❑ ATHLETE ❑ PARTICIPANT ❑ VOLUNTEER ❑ SPECTATOR ❑ BYSTANDER ❑ OFFICIAL
❑ OTHER:______

APPARENT INJURY OR DAMAGE
BODY PART:______
CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.):______
❑ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:______
❑ AMBULANCE, TAKEN TO:______ CITY:______
❑ FATALITY

OCCASION
WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT?______

INCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED:______

WITNESSES (If known)
NAME:______ NAME:______
ADDRESS:______ ADDRESS:______
PHONE: (   )______ PHONE: (   )______

INSURED
NAME OF INSURED:______ POLICY#:______
CLUB NAME:______ PHONE: (   )______
CITY:______ STATE:______

INSURED REPRESENTATIVE
❑ COACH ❑ OFFICIAL ❑ TRAINER ❑ PROMOTER ❑ TEAM/LEAGUE REPRESENTATIVE ❑ OTHER:______
NAME:______ PHONE: (   )______
TITLE:______ ORGANIZATION:______
SIGNATURE:______ DATE:______

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

(PA)1029_12-16

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Fort Wayne, Indiana 46801
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PARTICIPANT ACCIDENT OTHER INSURANCE FORM

Insured Name:______________________________

Policy Number:______________________________

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED. OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

MEDICAL BENEFITS UNDER THIS POLICY MAY PROVIDE PRIMARY, EXCESS OR A COMBINATION OF BOTH COVERAGES. UPON RECEIPT OF THIS CLAIM FORM , AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

IF THE MEDICAL BENEFIT IS EXCESS, YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL 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.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON:______________________________

FATHER'S NAME (if injured is a minor)______________________________

EMPLOYER NAME:______________________________

EMPLOYER ADDRESS:______________________________

CITY:____________________ STATE:__________ ZIP:__________

PHONE: (   )______________________________

GROUP INSURANCE COMPANY:______________________________

POLICY NUMBER:______________________________

INSURANCE COMPANY ADDRESS:______________________________

CITY:____________________ STATE:__________ ZIP:__________

DATE OF BIRTH:______________________________

SIGNATURE:______________________________

SPOUSE'S NAME (if applicable):______________________________

MOTHER'S NAME (if injured is a minor)______________________________

EMPLOYER NAME:______________________________

EMPLOYER ADDRESS:______________________________

CITY:____________________ STATE:__________ ZIP:__________

PHONE: (   )______________________________

GROUP INSURANCE COMPANY:______________________________

POLICY NUMBER:______________________________

INSURANCE COMPANY ADDRESS:______________________________

CITY:____________________ STATE:__________ ZIP:__________

DATE OF BIRTH:______________________________

SIGNATURE:______________________________

QUESTIONS REGARDING INCOME ARE ONLY APPLICABLE IF POLICY AFFORDS WEEKLY INDEMNITY BENEFITS.

REGULAR WEEKLY INCOME:______________________________

ON WHAT DATE DID YOU, OR DO YOU EXPECT TO,
RESUME WORK?______________________________

INCOME LOST PER WEEK DUE TO INJURY:______________________________

ON WHAT DATE DID YOU, OR DO YOU EXPECT TO,
RESUME RACING AND/OR PARTICIPATE IN A RACING EVENT?______________________________

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES 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 INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED:______________________________ DATE:____________________

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