

(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 pages 2 and 3 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

Attach current 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.

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.

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.



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

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.
- 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.
- We **MUST** have a copy of your USA Hockey Individual membership card, IMR form, or USA Hockey roster to process your claim.
- USA Hockey Insurance is an excess policy and may carry a **DEDUCTIBLE**.
- Keep a copy for your files.

(Mark all that apply. Complete relevant blanks.)

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: _____		

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:
 Home Game Away Game
 (To) (From) Game
 Warm-ups (Before Game)
 During Game (_____ Period)
 Between Periods
 After Game
 During Practice
 _____ Early
 _____ Mid
 _____ Late
 Practice/Scrimmage
 Other: _____

LOCATION:
 On Ice (Check box on illustration below.)
 _____ Defensive
 _____ Offensive
 Locker Room
 Spectator Seating
 Parking Lot
 Bench
 Other: _____

WITNESSES:
 Name: _____
 Phone: (____) _____
 Name: _____
 Phone: (____) _____

BOARD CONDITION:
 Plastic Poor (Old)
 Plywood Temporary
 Other: _____

SOURCE OF INJURY:
 Hit by Puck
 Hit by Stick
 Collided with
 _____ Goal
 _____ Boards
 _____ Opponent
 _____ Teammate
 Other: _____

Other Contact
 _____ Checked from Behind
 _____ Pushed from Behind
 _____ Struck by Opponent
 _____ Tripped by Opponent
 _____ High Sticking
 _____ Speared/Slashed
 _____ Open Ice Check
 Non-Contact Injury

FACE PROTECTION:
 Full Facemask None
 Half Shield Knocked Off

POSITION:
 Center Wing Goal
 Forward Defense

PENALTY:
 Was a penalty called? Yes No
 Penalty call on: Opponent
 Injured Player

PROTECTION ABOVE BOARDS:
 None Glass
 Netting Wire
 Other: _____

SURFACE CONDITION:

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 AND BE SUBJECT TO A \$1,000 DEDUCTIBLE. **IN ADDITION, THE DEDUCTIBLE PORTION OF ANY PRIMARY INSURANCE IS NEITHER COVERED NOR ELIGIBLE FOR REIMBURSEMENT BY THIS EXCESS POLICY.** COVERAGE IS ALSO LIMITED TO THOSE RELATED EXPENSES INCURRED WITHIN 3 YEARS FROM THE ACCIDENT DATE.

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.

Signature: _____ Date: _____

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