United States Specialty USSSA Sports Association

CASE REPORT

PLEASE COMPLETE AND SIGN USSSA CASE REPORT, USSSA ACCIDENT INSURANCE CLAIM FORM AND AUTHORIZATION FORM. ACCOMPANY FORMS WITH TEAM ROSTER AND CERTIFICATE OF INSURANCE APPLICABLE TO THIS CLAIM

K&K INSURANCE

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: 312.381.9077

ON BEHALF OF NATIONWIDE INSURANCE

Name of Injured Person:_____

Phone: (_____)_____

Address:_____

City:_____ State:_____ Zip:_____

Age:_____ Sex: (M) (F) Date of Birth:_____

Team Name as it appears on USSSA Certificate:_____

USSSA Certificate #:_____ USSSA Registration #:_____

Injury: ❑ Person ❑ Property Injured: ❑ Player ❑ Coach ❑ Umpire/Referee ❑ Volunteer

Date of Injury:_____ ❑ Morning ❑ Afternoon ❑ Evening ❑ Lights

Body Part Injured:_____ ❑ Left ❑ Right ❑ Both ❑ N/A

Disposition: ❑ On-Site Care Only ❑ Ambulance to_____ City:_____

Condition (Laceration, Concussion, Sprain, Fracture, etc.):_____

Does player have other insurance? ❑ Yes ❑ No If yes, company:_____

SPORT PROGRAM:

❑ Baseball ❑ Flag/Touch Football
❑ Basketball ❑ Softball
❑ Soccer ❑ Volleyball
❑ Other:_____

OCCASION:

❑ To/From Game ❑ To/From Practice
❑ Warmups
❑ During Game:
❑ Between Innings (_____ Inning)
❑ Practice: (Early) (Mid) (Late)
❑ Practice Game Conditions

SITUATION:

❑ Hit By:_____
❑ Hit:_____
❑ Fall: (Slip) (Trip) (Pushed)
❑ Non-Contact Injury
❑ Other:_____

LOCATION:

❑ Court/Links/Field
❑ Spectator Area
❑ Sport Facility/Other
(Locker Room) (Walkway)
❑ Parking Area
❑ Street/Road
❑ Other:_____

SURFACE INVOLVED:

❑ Grass ❑ Dirt
❑ Artificial ❑ Brick
❑ Wood ❑ Metal
❑ Other:_____

DESCRIBE HOW ACCIDENT HAPPENED:

_____
_____
_____
_____
_____
_____

ACTIVITY:

❑ While Participating
❑ Training/Exercising
❑ Observing
❑ Non-Sport Routine
❑ Altercation
❑ Game
❑ Other:_____

SPECIAL CIRCUMSTANCES:

❑ Not Applicable
❑ Protective Equipment Not Worn
❑ Despite Protective Equipment
❑ Rule Infraction: (Injured) (Another)
❑ Facility Related: (Explain)
_____
_____
❑ Other:_____
_____
_____
_____
_____

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

Signature of Coach or League Official (not related to injured person):_____

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 (312) 381-9077
Email: KK.PAClaims@kandkinsurance.com

1354-A 7/16

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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:_____

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

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc./Specialty Benefits 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 herby authorize any hospital, physician or other person who has attended me and my insurance carrier or employer to furnish to K&K Insurance Group, Inc./Specialty Benefits or its representatives any an all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, 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.

APPLICABLE IN ALABAMA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

APPLICABLE IN ALASKA
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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, KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, VIRGINIA, 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 LA, ME, TN, and VA, 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 THE DISTRICT OF COLUMBIA
Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA
Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or S. 775.084, Florida Statutes.

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 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.

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 KANSAS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MARYLAND
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

APPLICABLE IN 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 include imprisonment, fines and denial of insurance benefits.

FRAUD CLAIMS (2013/01)

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 prosecution.

Signature of Player: _____ Date: _____

Signature of Coach, Manager or Referee: _____ Date: _____

AFTER you receive your acknowledgement letter, you may contact K&K Insurance Group, Inc./Specialty Benefits at 1-800-237-2917, Option 1, if you have any questions about your claim.

MAIL TO: K&K Insurance Group, Inc./Specialty Benefits, Attn: PA Claims, P.O. Box 2338, Fort Wayne, IN 46801

Email: KK_PAClaims@kandkinsurance.com • Fax: 312-381-9077

The First Health Network HYGEIA PHCS