



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	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> PROPERTY DAMAGE <input type="checkbox"/> OTHER: _____
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: _____ EVENT TYPE: _____ SANCTIONED BY: _____ LOCATION: _____
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: () ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> SPECTATOR <input type="checkbox"/> BYSTANDER <input type="checkbox"/> OFFICIAL <input type="checkbox"/> OTHER: _____
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> 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	<input type="checkbox"/> COACH <input type="checkbox"/> OFFICIAL <input type="checkbox"/> TRAINER <input type="checkbox"/> PROMOTER <input type="checkbox"/> TEAM/LEAGUE REPRESENTATIVE <input type="checkbox"/> 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



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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: _____

SPOUSE'S NAME (if applicable): _____

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

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

EMPLOYER NAME: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____

PHONE: () _____

GROUP INSURANCE COMPANY: _____

GROUP INSURANCE COMPANY: _____

POLICY NUMBER: _____

POLICY NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE COMPANY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____

DATE OF BIRTH: _____

SIGNATURE: _____

SIGNATURE: _____

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

REGULAR WEEKLY INCOME: _____

INCOME LOST PER WEEK DUE TO INJURY: _____

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

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.