# **SUMMARY OF COVERAGE**

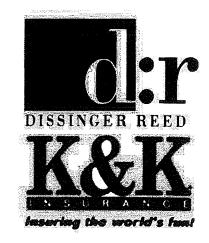
Coverage Period: 7/01/2015 – 7/01/2016 Carrier: Nationwide Life Insurance Company

AM Best Rated A+ XV

#### **Excess Accident Medical Limits:**

Maximum: \$ 25,000 per injury Usual & Customary 100% Benefit Period: 1 Year Deductible: \$0 per claim AD&SL \$5,000

AD&SL Aggregate \$250,000



# Eligible Person:

All athletes participating in a Covered Activity.

#### **Covered Activities:**

Participating in practice or play of sports governed and/or sponsored by the Participating Organization.

Participating Organization: An organization which:

- 1. Elects to offer coverage under the Policy by completing a Participating Organization Application that has been accepted by Us (Nationwide);
- 2. Completes a participation agreement with the Policyholder; and
- 3. Remits the required Premium when due.

# **Definition of Injury**

For the Accident medical Expense benefits, the following definition of Injury applies: A bodily injury which is:

- 1. Directly and independently caused by specific Accidental contact with another body or object;
- 2. a source of loss that is sustained while the Insured Person is covered under the Policy and while he or she is taking part in a Covered Activity.
- 3. Resulting in a concussion.

#### **Definition of Concussion**

A specific brain injury defined as a complex pathophysiological process affecting the brain, induced by trauma to the brain, and diagnosed by a Physician practicing within the scope of his or her license.

# How to File a Claim

#### To process your claim, please submit the following pieces of information:

- 1. Completed and Signed 'K&K Incident Report'
- 2. Complete and Signed 'Other Insurance Questionnaire'
- 3. Itemized Bills
- 4. Explanation of Benefits from your Primary Insurance Carrier

#### These documents should be mailed, emailed or faxed to:

K&K Insurance Group Attn: Terri Bruner 1712 Magnavox Way Fort Wayne, IN 46801

#### Terri.Bruner@kandkinsurance.com

(312) 381-9077 Fax (800) 237-2917 Toll Free

The 'K&K Incident Report' enables the payer to open a claim for the treatment of your injury. To avoid delays in claim processing, please be sure to complete the 'Other Insurance Questionnaire'. The incident report must be signed by an MHSAA member school administrator.

Itemized Bills – please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account Statements or 'Balance Due' statements are helpful, but do not contain all the information needed to process the claim.

Explanation of Benefits – If you have other medical insurance, all medical bills first be submitted to that carrier for its determination of eligibility and payment. If the charges are not paid in full by the other medical insurance carrier, we will need to see a copy of the 'Explanation of Benefits' prior to paying any benefits. If you do not have other insurance, the need for an 'Explanation of Benefits' will not apply to your claim.







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

Michigan High School Athletic Association Concussion Coverage

### (PLEASE PRINT)

NATURE	□ BODILY INJURY □ OTHER:		michigan high school athletic association	
TIME & PLACE OF INCIDENT	DATE:TIN EVENT NAME: EVENT TYPE: LOCATION:	CONDUCTED BY:		
HAPPENED TO	NAME: SEX:	e 🖵 Female PHONE: ()		
FUNCTION	AS: ATHLETE OTHER:			
APPARENT INJURY OR DAMAGE	BODY PART:			
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT?			
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED:			
<b>WITNESSES</b> (If known)	NAME:ADDRESS:PHONE:_()			
INSURED	NAME OF INSURED:CLUB NAME:CITY:	PHONE:_()		
INSURED REPRESENTATIVE	□ MHSAA Member School Administrator □ OTHEN NAME: TITLE: SIGNATURE:	PHONE: ()		

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



# OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT:	INTERNATIONAL STUDENT 🖵 Yes 🔲 No		
EMANCIPATED STUDENT:  Yes  No			
NAME OF INSURED:POLICY NO:			
FATHER	MOTHER		
_			
IS FATHER DECEASED?  Yes  No	IS MOTHER DECEASED?  Yes  No		
IS FATHER LEGALLY RESPONSIBLE? 🖵 Yes 💢 No	IS MOTHER LEGALLY RESPONSIBLE? ☐ Yes ☐ No		
FATHER'S NAME (if injured is a minor)	MOTHER'S NAME (if injured is a minor)		
SOCIAL SECURITY #:	SOCIAL SECURITY #:		
EMPLOYED? Tyes No SELF-EMPLOYED? Tyes No	EMPLOYED? ☐ Yes ☐ No SELF-EMPLOYED? ☐ Yes ☐ No		
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? 🖵 Yes 💢 No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE?  Yes  No		
EMPLOYER NAME:	EMPLOYER NAME:		
EMPLOYER ADDRESS:	EMPLOYER ADDRESS:		
CITY:STATE:ZIP:	CITY:STATE:ZIP:		
PHONE: ()	PHONE: ()		
CONTACT PERSON:	CONTACT PERSON:		
Do you have group medical insurance coverage through your employment?  Yes No  If no, please be advised K&K may contact your employer to verify no primary	Do you have group medical insurance coverage through your employment?  Yes No  If no, please be advised K&K may contact your employer to verify no primary		
insurance is in force.	insurance is in force.		
INSURANCE COMPANY:	INSURANCE COMPANY:		
INSURANCE COMPANY ADDRESS:	INSURANCE COMPANY ADDRESS:		
CITY:STATE:ZIP:	CITY:STATE:ZIP:		
POLICY NUMBER:	POLICY NUMBER:		
TYPE OF PLAN:	TYPE OF PLAN:  HEALTH MAINTENANCE ORGANIZATION (HMO)		
☐ PREFERRED PROVIDER ORGANIZATION (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)		
STANDARD MEDICAL AND HOSPITALIZATION COVERAGE	☐ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE		
OTHER (describe)	OTHER (describe)		
	OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING		
PARENT/GUARDIAN/FATHER SIGNATURE:	PARENT/GUARDIAN/MOTHER SIGNATURE:		
DATE:	DATE:		