SPECIALTY BENEFITS, INC.
an affiliate of K&K Insurance Group, Inc.

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph:800-237-2917 | Fax: 312-381-9077 California License #0334819
email: kk.PAClaims@kandkinsurance.com
www.kandkinsurance.com

STUDENT OR ATHLETE ACCIDENT CLAIM FORM
Excess Coverage
K-12 ACCOUNTS

INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Student's Name Last: ______ First: ______ MI: ______
2. Date of Birth: ______ SS# ______ Sex: ☐ Male ☐ Female
3. Student's grade in school: ______ Email address: ______
4. Home Address Street: ______
   City: ______ State: ______ Zip: ______
   Parent(s)/Guardian(s) Home Phone: ______
5. Date of Accident: ______ Time of Accident: ______ ☐ AM ☐ PM
   Nature of Injury: ______ Describe exactly how accident happened: ______
   ______
6. Nature of activity and location during which the injury occurred (check all boxes which apply):
   - ☐ Pre-Kindergarten
   - ☐ Elementary School
   - ☐ Middle School
   - ☐ High School
   - ☐ Cafeteria
   - ☐ Classroom Activities
   - ☐ Interscholastic Sports
   - ☐ Intramural Sports, *name of sport, if applicable*: ______
   - ☐ Club Sports
   - ☐ Physical Education Class
   - ☐ Other Activity (specify) ______
   - ☐ During Practice
   - ☐ During Play
   - ☐ During Travel To or From the Event

   Nature of Your Participation:
   - ☐ Student
   - ☐ Volunteer
   - ☐ Student/Manager
   - ☐ Athletic Participant
   - ☐ Cheerleader
   - ☐ Band Member
   - ☐ Other (specify) ______
7. Transfer Student? ☐ Yes ☐ No
   If yes, please identify the former school name: ______
8. Name, address and phone number of physician who first treated you: ______
   ______

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

1675H 10/20

9. Have you had a similar injury in the past? ☐ Yes ☐ No
   If yes, describe and give dates:______________________________

10. Name, address and phone number of physician who treated you for previous injury:______________________________

____

11. Are you covered by any other medical expense benefits plan? ☐ Yes ☐ No
    If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

____

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS *EXCESS* MEDICAL COVERAGE.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits and/or The Hartford or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms for insurance 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.

Date______________ Parent/Guardian Signature ______________________________

SECTION II – (TO BE COMPLETED BY PARTICIPATING SCHOOL)

FAILURE TO COMPLETE THIS FORM IN FULL
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Students Name: Last ______________ First______________ MI______
2. Date of Accident______________________________
3. Activity ______________________________
4. Nature of Injury ______________________________
5. Name of participating SCHOOL SYSTEM or SCHOOL DISTRICT______________________________
6. Name of participating SCHOOL______________________________
7. 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 criminal prosecution.

   SIGNATURE OF SCHOOL OFFICIAL:______________________________

   PRINTED NAME/TITLE:______________________________

   PHONE:______________________ FAX:______________________

   EMAIL:______________________ DATE:______________

   Any person who knowingly and with intent to defraud any insurance company or other person files claim forms for insurance 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.

   Date__________ Policyholder (School Official) Signature______________________________

Dear Participant: If you have an appointment with a doctor as the result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates:

INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT /GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. 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.

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT:____________________ INTERNATIONAL STUDENT ❑ Yes ❑ No

EMANCIPATED STUDENT: ❑ Yes ❑ No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: ❑ Yes ❑ No

NAME OF INSURED:____________________ POLICY NO:____________________

FATHER

IS FATHER DECEASED? ❑ Yes ❑ No

IS FATHER LEGALLY RESPONSIBLE? ❑ Yes ❑ No

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

DATE OF BIRTH:____________________

EMPLOYED? ❑ Yes ❑ No SELF-EMPLOYED? ❑ Yes ❑ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ❑ Yes ❑ No

EMPLOYER NAME:____________________

EMPLOYER ADDRESS:____________________

CITY:__________ STATE:_____ ZIP:_____

PHONE: (_____)____________________

CONTACT PERSON:____________________

Do you have group medical insurance coverage through your employment?

❑ Yes ❑ No

If Yes, is it: ❑ Individual ❑ Family

If No, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:____________________

INSURANCE COMPANY ADDRESS:____________________

CITY:__________ STATE:_____ ZIP:_____

POLICY NUMBER:____________________

TYPE OF PLAN:
❑ HEALTH MAINTENANCE ORGANIZATION (HMO)
❑ PREFERRED PROVIDER ORGANIZATION (PPO)
❑ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
❑ OTHER (describe)____________________

MOTHER

IS MOTHER DECEASED? ❑ Yes ❑ No

IS MOTHER LEGALLY RESPONSIBLE? ❑ Yes ❑ No

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

DATE OF BIRTH:____________________

EMPLOYED? ❑ Yes ❑ No SELF-EMPLOYED? ❑ Yes ❑ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ❑ Yes ❑ No

EMPLOYER NAME:____________________

EMPLOYER ADDRESS:____________________

CITY:__________ STATE:_____ ZIP:_____

PHONE: (_____)____________________

CONTACT PERSON:____________________

Do you have group medical insurance coverage through your employment?

❑ Yes ❑ No

If Yes, is it: ❑ Individual ❑ Family

If No, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:____________________

INSURANCE COMPANY ADDRESS:____________________

CITY:__________ STATE:_____ ZIP:_____

POLICY NUMBER:____________________

TYPE OF PLAN:
❑ HEALTH MAINTENANCE ORGANIZATION (HMO)
❑ PREFERRED PROVIDER ORGANIZATION (PPO)
❑ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
❑ OTHER (describe)____________________

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE:____________________ PARENT/GUARDIAN/MOTHER SIGNATURE:____________________

DATE:__________ DATE:__________

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.