ZURICH AMERICAN INSURANCE COMPANY

K12 - PROOF OF CLAIM – ACCIDENT MEDICAL EXPENSE

Mail/Email/Fax claims to:

K&K Insurance/Specialty Benefits
P. O. BOX 2338
Ft. Wayne, IN 46801
Fax: 312-381-9077 Toll Free: 800-237-2917
Email: kk.PAClaims@kandkinsurance.com

PART A

Policy Number:	Policyholder:
Member Name	Relationship to Member:
Name of Claimant(if different)	Date of Birth
Mailing Address	Social Security No.
Name and Address of Attending Physician/Dentist	

Part B	Date of Accident	Place of Accident / Facility Name
	Diagnosis	Type of Sport (if applicable)
	Describe the Accident	
	What part of the body was injured?	Which Side? R L (if applicable)
	At the time of the accident, was the injured person involved in an activity sponsored and supervised by the policyholder? Yes No	
	Name of the Supervisor	Was he / she a witness to the accident? Yes No
	Policyholder Verification Name Title	Date

Part C

Name of Member	Social Security #	Relationship: Father ☐ Mother ☐ Guardian ☐ Other ☐		
Address (Number) Street (Lot or Apt. No.)	City	State	Zip Code	
Area Code – Home Telephone Number	Area Code – Work Telephone & Extension			
Occupation of Father or Male Guardian	Place of Employment	Employer: Area Code – Phone Number		
Occupation of Mother or Female Guardian	Place of Employment	Employer: Area Code – Phone Number		
Do you have any other health and/or accident insurance plan (other than this plan)? Claimant: Yes ☐ No ☐ Father: Yes ☐ No ☐ Mother: Yes ☐ No ☐ Guardian: Yes ☐ No ☐				
Is the injured person covered by other health and/or accident insurance plan?				
Name of other health and/or accident insurance company Address Policy Number				

* **INCLUDE ITEMIZED BILLS FOR MEDICAL TREATMENT AND YOUR PRIMARY INSURANCE CARRIER(S) BENEFIT SUMMARIES (EOB'S)**

(AUTHORIZATION MUST BE COMPLETED BY CLAIMANT, OR PARENT OR GUARDIAN IF CLAIMANT IS A MINOR)

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of claimant and any other non-medical information of claimant to give ZURICH AMERICAN INSURANCE COMPANY or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by ZURICH AMERICAN INSURANCE COMPANY to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by ZURICH AMERICAN INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request a copy of this Authorization. I AGREE that a photographic or photostatic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim

_____ _____

Signature of Member, or Parent or Guardian if Claimant is a minor Date

FRAUD STATEMENT

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."

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."

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

CALIFORNIA: "For your protection California law requires the following to appear on this form: Any person who knowingly present false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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."

DELAWARE: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

WASHINGTON D.C.: "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 were provided by the applicant."

FLORIDA: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

IDAHO: "Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

I**NDIANA**: "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."

KENTUCKY: "Any person who knowingly and with intent to defraud any insurance company or other 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."

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

MAINE: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

MINNESOTA: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

NEW HAMPSHIRE: "Any person who, with a 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."

NEW JERSEY: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." Substantially similar language must be approved by the DOI.

NEW MEXICO: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

OHIO: "Any person who, with intent to defraud or knowing that he 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."

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."

OREGON: “I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act which is a crime and such person may be guilty of insurance fraud.”

PENNSYLVANIA: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties."

TENNESSEE: "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."

TEXAS: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

VIRGINIA: "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."

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."

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

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.