CASE REPORT AND ACCIDENT INSURANCE CLAIM FORM

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

(NOTE: Report and Claim Form will be returned if not fully completed and signed.)

Basic Procedures for Submitting Case Report and Accident Insurance Claim Form

1. The participant or participant's parents/guardian should complete page 2 of the form, and forward it to K&K Insurance Group, Inc.
2. The coach/program administrator must sign the completed case report.
3. If referee claim, the Referee in Chief must sign the completed case report.

To the Athlete/Parent/Guardian/Coach/Referee/Volunteer

Once the completed claim form has been submitted, forward itemized physician, hospital or other provider's bills for accident medical expenses claimed as well as the primary carrier's Explanation of Benefits showing payments and denials. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. THESE DOCUMENTS MUST BE SUBMITTED WITHIN 15 MONTHS FROM THE ACCIDENT DATE IN ORDER TO BE ELIGIBLE FOR COVERAGE.

K&K INSURANCE GROUP, INC. / SPECIALTY BENEFITS, INC.
Claims Department, P.O. Box 2338, Fort Wayne, Indiana 46801-2338
(800) 237-2917

The First Health Network

HYGEIA

PHCS

Instructions for Completing the Accident Insurance Form to the Injured Person/Parent/Guardian

To the injured person/parent/guardian: 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.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefit and may be subject to civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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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 option 1, then 3
Fax (312) 381-9077
email: KK.PAClaims@kandkinsurance.com

USA Hockey Case Report

For registered Players/Coaches/ Referees/ Volunteers

USA HOCKEY

PLEASE REMEMBER

1. You must return this form to: USA Hockey, c/o K&K Insurance Group – Claims Dept., 1712 Magnavox Way, P.O. Box 2338, Fort Wayne, IN 46801-2338. Fax: 312-381-9077, email: KK.PAClaims@kandkinsurance.com
2. Do ***NOT*** take this form to your medical provider for completion: ***YOU MUST FILL IT OUT.***
3. YOU and your COACH/PROGRAM ADMINISTRATOR ***MUST SIGN*** this form.
4. Please submit this form to K&K Insurance immediately upon completion. Do not wait for medical bills. **The completed form, itemized bills and primary plan Explanation of Benefits must be submitted within 15 months from the date of the accident.**
5. USA Hockey Insurance is an excess policy and members with primary insurance must meet a $1,000 out-of-pocket expense obligation. Members with no primary insurance must meet a $3,500 deductible.
6. Keep a copy for your files.

(Mark all that apply. Complete relevant blanks.)

LEVEL OF PLAY: ☐ 8 & Under ☐ 10 & Under ☐ 12 & Under ☐ 14 & Under ☐ 16 & Under ☐ 18 & Under ☐ Adult

TYPE OF TEAM: ☐ Youth ☐ Girls/Women ☐ Adult ☐ Major Jr / Tier 1 ☐ Junior A, B, C ☐ Other_____

☐ League Play ☐ Tournament ☐ Practice ☐ Other:_____

Program Name: _____
Rink Name: _____
City/State: _____

INJURED: (Player) (Referee) (Coach) Other: _____
Name: _____ Birthdate: _____ Gender: (M) (F)
Address: _____ Phone: (_____) _____
City: _____ State: _____ Zip: _____
Team Name: _____
If during a game, name of opposing team: _____

INJURY: Date of Injury: _____ Body part injured: _____
Describe nature of injury (fracture, contusion, concussion, paralysis, dislocation, sprain, etc.): _____

TIME: ☐ Morning ☐ Afternoon ☐ Evening ☐ After Hours

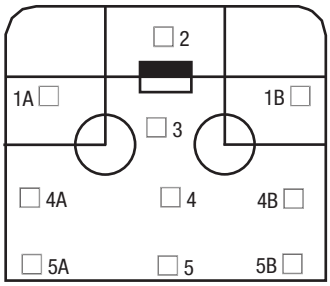
DISPOSITION: ☐ On-Site Care Only ☐ Hospital by: ☐ Ambulance ☐ Car ☐ Refused Care

OCCASION:
☐ Home Game ☐ Away Game
☐ (To) (From) Game
☐ Warm-ups (Before Game)
☐ During Game (____ Period)
☐ Between Periods
☐ After Game
☐ During Practice
____ Early
____ Mid
____ Late
☐ Practice/Scrimmage
Other:

BOARD CONDITION: ☐ Plastic ☐ Poor (Old) ☐ Plywood ☐ Temporary ☐ Other:

PROTECTION ABOVE BOARDS: ☐ None ☐ Glass ☐ Netting ☐ Wire ☐ Other:

LOCATION:
☐ On Ice (Check box on illustration below.)
☐ Defensive
☐ Offensive
☐ Locker Room
☐ Spectator Seating
☐ Parking Lot
☐ Bench
☐ Other:



SOURCE OF INJURY:
☐ Hit by Puck
☐ Hit by Stick
☐ Collided with
☐ Goal
☐ Boards
☐ Opponent
☐ Teammate
☐ Other:
☐ Other Contact
☐ Checked from Behind
☐ Pushed from Behind
☐ Struck by Opponent
☐ Tripped by Opponent
☐ High Sticking
☐ Speared/Slashed
☐ Open Ice Check
☐ Non-Contact Injury

WITNESSES:
Name: _____
Phone:(___) _____
Name: _____
Phone:(___) _____

FACE PROTECTION: ☐ Full Facemask ☐ None ☐ Half Shield ☐ Knocked Off

POSITION: ☐ Center ☐ Wing ☐ Goal ☐ Forward ☐ Defense

PENALTY:
Was a penalty called? ☐ Yes ☐ No
Penalty call on: ☐ Opponent ☐ Injured Player

SURFACE: ☐ Regular ice ☐ Artificial ice

DESCRIBE HOW ACCIDENT HAPPENED: (Be specific.) _____

NON-REFEREE INJURIES

I verify that this injury occurred during a USA Hockey sanctioned "event".

Coach/Program Administrator (Print name): _____
(Signature): _____ Phone: (_____) _____ Date: _____

REFEREE INJURIES

REFEREE CLAIMS MUST BE MAILED TO DISTRICT REFEREE IN CHIEF FOR VERIFICATION AND SIGNATURE

USA Hockey District: _____ Was the above referee a registered official at the time of injury? ☐ YES ☐ NO
Registration Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Did this injury occur during a USA Hockey sanctioned event? ☐ YES ☐ NO
Signature of District Referee in Chief: _____ Date: _____

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USA HOCKEY ACCIDENT MEDICAL INSURANCE CLAIM FORM

PLEASE NOTE: If Injured Person is a Minor, we must have BOTH parents' information. If the injured person is married, we must have the spouse's information or mark area N/A.

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE PROVIDED. OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

TO BE COMPLETED BY INJURED PERSON OR PARENT

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER VALID AND COLLECTIBLE HEALTH AND ACCIDENT PLANS. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN, YOUR PARENTS' OR YOUR SPOUSE'S 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. IF THERE IS NO OTHER VALID AND COLLECTIBLE INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. FURTHER DETAILS OF COVERAGE WILL BE COMMUNICATED TO YOU UPON RECEIPT OF THIS FULLY COMPLETED CLAIM FORM.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. THE DATA REQUESTED IS IMPERATIVE AND WILL EXPEDITE YOUR CLAIM PROCESSING.

Insured Person's Name:_____ **Spouse's Name (If applicable.):**_____

Father's Name (If minor.):_____ **Mother's Name (If minor.):**_____

Social Security No.:_____ **Social Security No.:**_____

Employer's Name:_____ **Employer's Name:**_____

Employer's Address:_____ **Employer's Address:**_____

City:_____ **State:**_____ **Zip:**_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____ **Policy No.:**_____ **Phone:**_____ **Policy No.:**_____

Group Insurance Company:_____ **Group Insurance Company:**_____

Insurance Company's Address:_____ **Insurance Company's Address:**_____

City:_____ **State:**_____ **Zip:**_____ **City:**_____ **State:**_____ **Zip:**_____

I certify that this injury occurred to a USA Hockey registered member during a USA Hockey sanctioned activity (supervised game/practice, not pickup hockey), the above information is true and accurate to the best of my knowledge and belief, and I understand fraudulent statements can be a crime.

Signature:_____ **Date:**_____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K INSURANCE GROUP, INC., SPECIALTY BENEFITS, INC. OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY PRIMARY 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 PRIMARY 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 QUICKLY PROCESS MY CLAIM.

• Depending on the severity of your injury, would you mind being contacted by the USA Hockey Catastrophic Injury Registry for further information? ☐ Yes ☐ No

Signature:_____ **Date:**_____

PLEASE NOTE: If Injured Person is a Minor, signature must be of Parent or Legal Guardian.

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