

TIPS FOR EFFICIENT STUDENT ACCIDENT CLAIM PROCESSING

1. The Claim Form must be completed in its entirety and signed by both parents and a school official.
2. The date of the accident and a detailed description are required to verify that the incident was school-related.
3. The claim form should be submitted to K&K Insurance within 60 days of the accident. **THE BASIC COVERAGE HAS A BENEFIT PERIOD OF TWO YEARS FROM THE DATE OF THE ACCIDENT. TREATMENT MUST OCCUR WITHIN 60 DAYS OF THE ACCIDENT.**
4. In addition to the claim form, the company will also require the following in order to make payment:
 - Itemized physician, hospital, or other provider bill that includes the diagnostic and procedure codes
NOTE: for hospital charges, a Form UB04 is required. For physical/ancillary charges, a Form CMS1500 is required.
 - Explanation of Benefits from primary carrier

For questions regarding claims:

Roberts Insurance & Investments

Bobbi Land bobbi@bobrobertsins.com or
Stephanie Branham stephanie@bobrobertsins.com
859-623-7684 or 1-877-757-2581



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

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 | Fax: 312-381-9077 California License #0334419
email: kk.PAclaims@kandkinsurance.com
www.kandkinsurance.com

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 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: _____
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):

<input type="checkbox"/> Pre-Kindergarten	<input type="checkbox"/> Elementary School	<input type="checkbox"/> Middle School
<input type="checkbox"/> High School	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Classroom Activities
<input type="checkbox"/> Interscholastic Sports	<input type="checkbox"/> Intramural Sports, <i>name of sport, if applicable:</i> _____	<input type="checkbox"/> Other Activity (specify) _____
<input type="checkbox"/> Club Sports	<input type="checkbox"/> Physical Education Class	<input type="checkbox"/> During Travel To or From the Event
<input type="checkbox"/> During Practice	<input type="checkbox"/> During Play	

Nature of Your Participation:

<input type="checkbox"/> Student	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Student/Manager
<input type="checkbox"/> Athletic Participant	<input type="checkbox"/> Cheerleader	<input type="checkbox"/> Band Member
<input type="checkbox"/> 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: _____

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 Zurich Insurance 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. Student's 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 _____



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	MOTHER
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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 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) _____

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 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: _____
 DATE: _____

PARENT/GUARDIAN/MOTHER SIGNATURE: _____
 DATE: _____