



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

**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 #0334819  
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 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: \_\_\_\_\_
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. 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 \_\_\_\_\_

**TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)**



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**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
IS FATHER DECEASED? <input type="radio"/> Yes <input type="radio"/> No	IS MOTHER DECEASED? <input type="radio"/> Yes <input type="radio"/> No
IS FATHER LEGALLY RESPONSIBLE? <input type="radio"/> Yes <input type="radio"/> No	IS MOTHER LEGALLY RESPONSIBLE? <input type="radio"/> Yes <input type="radio"/> No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
SOCIAL SECURITY #: _____	SOCIAL SECURITY #: _____
EMPLOYED? <input type="radio"/> Yes <input type="radio"/> No SELF-EMPLOYED? <input type="radio"/> Yes <input type="radio"/> No	EMPLOYED? <input type="radio"/> Yes <input type="radio"/> No SELF-EMPLOYED? <input type="radio"/> Yes <input type="radio"/> No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="radio"/> Yes <input type="radio"/> No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	Do you have group medical insurance coverage through your employment? <input type="radio"/> Yes <input type="radio"/> No
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary 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: <input type="radio"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="radio"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="radio"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGE <input type="radio"/> OTHER (describe) _____	TYPE OF PLAN: <input type="radio"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="radio"/> PREFERRED PROVIDER ORGANIZATION (PPO) <input type="radio"/> STANDARD MEDICAL AND HOSPITALIZATION COVERAGES <input type="radio"/> 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: \_\_\_\_\_