United States Specialty USSSA Sports Association

# CASE REPORT

**PLEASE COMPLETE AND SIGN USSSA CASE REPORT, USSSA ACCIDENT INSURANCE CLAIM FORM AND AUTHORIZATION FORM. ACCOMPANY FORMS WITH TEAM ROSTER AND CERTIFICATE OF INSURANCE APPLICABLE TO THIS CLAIM**

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
Fax: 260.459.5915
ON BEHALF OF NATIONWIDE INSURANCE

Name of Injured Person:_____
Phone: (_____)_____
Address:_____
City:_____ State:_____ Zip:_____
Age:_____ Sex: (M) (F) Date of Birth:_____
Team Name as it appears on USSSA Certificate:_____
USSSA Certificate #:_____ USSSA Registration #:_____

Injury: ❑ Person ❑ Property Injured: ❑ Player ❑ Coach ❑ Umpire/Referee ❑ Volunteer
Date of Injury:_____ ❑ Morning ❑ Afternoon ❑ Evening ❑ Lights
Body Part Injured:_____ ❑ Left ❑ Right ❑ Both ❑ N/A
Disposition: ❑ On-Site Care Only ❑ Ambulance to_____ City:_____
Condition (Laceration, Concussion, Sprain, Fracture, etc.):_____
Does player have other insurance? ❑ Yes ❑ No If yes, company:_____

**SPORT PROGRAM:**
❑ Baseball ❑ Flag/Touch Football
❑ Basketball ❑ Softball
❑ Soccer ❑ Volleyball
❑ Other:_____

**OCCASION:**
❑ To/From Game ❑ To/From Practice
❑ Warmups
❑ During Game:
❑ Between Innings (_____ Inning)
❑ Practice: (Early) (Mid) (Late)
❑ Practice Game Conditions

**SITUATION:**
❑ Hit By:_____
❑ Hit:_____
❑ Fall: (Slip) (Trip) (Pushed)
❑ Non-Contact Injury
❑ Other:_____

**LOCATION:**
❑ Court/Links/Field
❑ Spectator Area
❑ Sport Facility/Other
(Locker Room) (Walkway)
❑ Parking Area
❑ Street/Road
❑ Other:_____

**SURFACE INVOLVED:**
❑ Grass ❑ Dirt
❑ Artificial ❑ Brick
❑ Wood ❑ Metal
❑ Other:_____

**DESCRIBE HOW ACCIDENT HAPPENED:**

**ACTIVITY:**
❑ While Participating
❑ Training/Exercising
❑ Observing
❑ Non-Sport Routine
❑ Altercation
❑ Game
❑ Other:_____

**SPECIAL CIRCUMSTANCES:**
❑ Not Applicable
❑ Protective Equipment Not Worn
❑ Despite Protective Equipment
❑ Rule Infraction: (Injured) (Another)
❑ Facility Related: (Explain)
❑ Other:_____

**THIS PORTION MUST BE COMPLETED IN ITS ENTITY BY A COACH OR LEAGUE OFFICIAL**

Signature of Coach or League Official (not related to injured person):_____
Print Name of Coach or League Official:_____ Phone # (_____)_____
Address:_____ City:_____ State:_____ Zip:_____

**Return completed form to: K&K Insurance Group, Inc. / Specialty Benefits Claims Department, PO Box 2338, Fort Wayne, IN 46801-2338**
***PLEASE ALLOW 15 BUSINESS DAYS FOR PROCESSING***
(800) 237-2917 • Fax (260) 459-5915

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# ACCIDENT INSURANCE CLAIM FORM

## PLEASE READ INSTRUCTIONS

**COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER INSURANCE. YOUR CLAIM MUST BE SUBMITTED TO YOUR PRIMARY INSURANCE CARRIER THAT INCLUDES A PERSONAL, EMPLOYERS OR GOVERNMENTAL HEALTH PLAN. AFTER PRIMARY INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE PRIMARY INSURANCE COMPANY'S EXPLANATION OF BENEFITS FORM.**

**IF YOUR PRIMARY INSURANCE CARRIER DENIES BENEFITS, SEND A COPY OF THE DENIAL ALONG WITH YOUR ITEMIZED MEDICAL BILLS. THESE MEDICAL BILLS MUST INDICATE THE PATIENTS NAME, CONDITION, TYPE OF TREATMENT, DATE THE EXPENSE OCCURRED AND CHARGES MADE. DEDUCTIBLES WILL BE IMPOSED DEPENDING ON THE COVERAGE DESCRIPTION.**

## TO BE COMPLETED BY INJURED PERSON OR PARENT

**Minor Injured Party:**_____

(Please complete following "other insurance" section for each parent/guardian.)

Injured Person:_____

Employer Name:_____

Employer Address:_____

City:_____ St:_____ Zip_____

Phone: (_____)_____ Policy #:_____

Group Insurance Company:_____

Ins. Co. Address:_____

City:_____ St:_____ Zip_____

Social Security Number:_____

Signature:_____ Date:_____

**Adult Injured Party:**_____

(Please complete following "other insurance" section for yourself as well as spouse.)

Parent or Spouse Name:_____

Employer Name:_____

Employer Address:_____

City:_____ St:_____ Zip_____

Phone: (_____)_____ Policy #:_____

Group Insurance Company:_____

Ins. Co. Address:_____

City:_____ St:_____ Zip_____

Social Security Number:_____

Signature:_____ Date:_____

**I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVE 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 PROPER INFORMATION NEEDED TO PROCESS MY CLAIM.**

_____ _____

**Signed** **Date**

**Please Note: If injured person is a minor, signature must be of parent or legal guardian.**

**Return completed form to: K&K Insurance Group, Inc. / Specialty Benefits**
**Claims Department, PO Box 2338, Fort Wayne, IN 46801-2338**

## AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc./Specialty Benefits 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 herby authorize any hospital, physician or other person who has attended me and my insurance carrier or employer to furnish to K&K Insurance Group, Inc./Specialty Benefits or its representatives any an all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, 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.

**For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, 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 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.

**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 Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 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 benefits and may be subject to any 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 by 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 be 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.

***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 prosecution.***

Signature of Player: _____ Date: _____

Signature of Coach, Manager or Referee: _____ Date: _____

***AFTER you receive your acknowledgement letter, you may contact K&K Insurance Group, Inc./Specialty Benefits at 1-800-237-2917, Option 1, if you have any questions about your claim.***

## MAIL TO:

**K&K Insurance Group, Inc./Specialty Benefits, Attn: PA Claims, P.O. Box 2338, Fort Wayne, IN 46801**

**Email: KK_PAClaims@kandkinsurance.com • Fax: 312-381-9077**

The First Health Network

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