



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.

| 1. St | udent's Name Last: | First: | | MI: | | |
|-------|--|--|--|-----------------------------|--|--|
| | | SS# | | | | |
| 3. St | udent's grade in school: | Email address: | | | | |
| | | | | | | |
| | | | | Zip: | | |
| | | | | | | |
| | te of Accident: | Time of Accident: | | O AM O PM | | |
| Na | ature of Injury: | Describe exactly how accident happened: | | | | |
| | Pre-Kindergarten | which the injury occurred (check all boxes which O Elementary School | O Middle School | | | |
| (| Pre-Kindergarten High School | O Elementary School O Cafeteria | | vities | | |
| (| Pre-Kindergarten | O Elementary SchoolO CafeteriaO Intramural Sports, <i>name of sport, if applicable:</i> | O Middle School O Classroom Activ | | | |
| 0 | Pre-Kindergarten High School Interscholastic Sports | O Elementary School O Cafeteria | O Middle School O Classroom Activ O Other Activity (s | pecify) o or From the Event | | |
| | Pre-Kindergarten High School Interscholastic Sports Club Sports | O Elementary School O Cafeteria O Intramural Sports, name of sport, if applicable: O Physical Education Class | O Middle School O Classroom Activ O Other Activity (s | pecify) | | |
| 0 | Pre-Kindergarten High School Interscholastic Sports Club Sports During Practice | O Elementary School O Cafeteria O Intramural Sports, name of sport, if applicable: O Physical Education Class | O Middle School O Classroom Activ O Other Activity (s | pecify) o or From the Event | | |
| | Pre-Kindergarten High School Interscholastic Sports Club Sports During Practice lature of Your Participation: | O Elementary School O Cafeteria O Intramural Sports, name of sport, if applicable: O Physical Education Class O During Play | O Middle School O Classroom Activ O Other Activity (s O During Travel To | pecify) o or From the Event | | |
| | Pre-Kindergarten High School Interscholastic Sports Club Sports During Practice lature of Your Participation: Student | O Elementary School O Cafeteria O Intramural Sports, name of sport, if applicable: O Physical Education Class O During Play O Volunteer | O Middle School O Classroom Activ O Other Activity (s O During Travel To | pecify) o or From the Event | | |
| | Pre-Kindergarten High School Interscholastic Sports Club Sports During Practice lature of Your Participation: Student Athletic Participant | O Elementary School O Cafeteria O Intramural Sports, name of sport, if applicable: O Physical Education Class O During Play O Volunteer | O Middle School O Classroom Activ O Other Activity (s O During Travel To | pecify) o or From the Event | | |

| 9. | Have you had a similar injury | in the past? O Yes O No | | | | | |
|--|--|--|--|---|--|--|--|
| | If yes, describe and give date | es: | | | | | |
| 10. | O. Name, address and phone number of physician who treated you for previous injury: | | | | | | |
| 11. Are you covered by any other medical expense benefits plan? O Yes O No | | | | | | | |
| | If yes, give the names of the | plan(s) and the person(s) through | h whom you are insured and their rela | ationship to you: | | | |
| PRO THE | MDE A STATEMENT FROM RE | THE EMPLOYER(S) INDICATIN | OU AND/OR YOUR SPOUSE ARE L IG YOUR CHILD IS NOT COVERED |) BY ANY INSURANCE OFFERED | | | |
| ALL | BENEFITS WILL BE MADE F | | SERVICE INVOLVED, UNLESS ACC E DICAL COVERAGE. | COMPANIED BY PAID RECEIPTS. | | | |
| | | | DICAL COVEIVAGE. | | | | |
| that Insur | has any records of knowled | ge of me, and/or the above na | I facility, insurance company, or othe amed claimant, to disclose, whene n information. A photocopy of this au | ever requested to do so by K&K | | | |
| mate | person who knowingly and with rially false information or conc ance act, which is a crime. | n intent to defraud any insurance eals, for the purpose of misleading | company or other person files claim g, information concerning any fact ma | forms for insurance containing any aterial thereto commits a fraudulent | | | |
| Date | | Parent/Guardian Signature | _ | | | | |
| | | | | 1 | | | |
| SE | CTION II | (TO BE COMPLETED B) | Y PARTICIPATING SCHOOL) | | | | |
| | MAY RESULT | | TE THIS FORM IN FULL AY IN THE PROCESSING OF T | THIS CLAIM. | | | |
| 1. | Student's Name Last: | Fir | rst: | MI: | | | |
| 2. | Date of Accident | | | | | | |
| 3. | Activity | | | | | | |
| 4. | Nature of Injury | | | | | | |
| 5. | | | NCT | | | | |
| 6. | | | | | | | |
| 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: | | | | | |
| | | | - | | | | |
| | | | FAX: | | | | |
| | | | DATE: | | | | |
| mate | person who knowingly and w | ith intent to defraud any insuran | ce company or other person files for g, information concerning any fact ma | orms for insurance containing any | | | |
| | | Dollarholder (Cabas LOfficial) C | Nonatura | | | | |
| Date | | Policyholder (School Official) S | nyi ialui C | | | | |

- In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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.
- For Residents of Alabama: 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 restitution fines and confinement in prison, or any combination thereof.
- 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 or award payable from Insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- For residents of the District of Columbia: 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 was provided by the applicant.
- 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.

IMPORTANT NOTICE

- For residents of Kentucky: Any person who knowingly and with intent to defraud any Insurance company or other person files 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 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 include imprisonment, fines and denial of insurance benefits.
- For residents of Oregon: Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- For residents of Maryland: Any person who knowingly of 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- For residents of 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.

- For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files and 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 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.
- For residents of Oklahoma: <u>WARNING</u>: 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.
- 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- For residents of 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.
- For residents of Virginia: Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

[AXIS_FRAUD 0220]

Dear Participant:

If you have an appointment with a doctor as a result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates.







INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT/GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. 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.





OTHER INSURANCE QUESTIONNAIRE

| NAME OF CLAIMANT: INTERNATIONAL STUDENT O Yes O No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: O Yes O No NAME OF INSURED: FATHER MOTHER IS FATHER DECASED? O Yes O No IS FATHER LEGALLY RESPONSIBLE? O Yes O No IS FATHER LEGALLY RESPONSIBLE? O Yes O No IS FATHER LEGALLY RESPONSIBLE? O Yes O No DATE OF BIRTH: MOTHER LEGALLY RESPONSIBLE? O Yes O No DATE OF BIRTH: MOTHER LEGALLY RESPONSIBLE? O Yes O No DATE OF BIRTH: MOTHER LEGALLY RESPONSIBLE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? DATE OF BIRTH: MOTHER LEGALLY RESPONSIBLE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? DATE OF BIRTH: MOTHER LEGALLY RESPONSIBLE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? DY SO NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O No DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O Yes O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O YES O NO DISABLED ON MEDICAD OR OTHER PUBLIC ASSISTANCE? O YES O NO DISABLED ON MEDICAD | N S U R A N C E | /4/N/ <i>j</i> | | QUESTI | | |
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Please Note: If injured person is a minor, signature must be of parent or legal guardian.

DATE:

AXIS INSURANCE COMPANY

(A Stock Company)

(Herein called the Company)

Administrative Office: Princeton, NJ 08540

Home Office: 1 University Square Drive, Suite 200 111 South Wacker Drive, Suite 3500 Chicago, IL 60606

BLANKET ACCIDENT POLICY/CERTIFICATE **AMENDMENT**

POLICY AMENDMENT NO. 0000 POLICY RENEWAL

POLICYHOLDER: WELD COUNTY SCHOOL DISTRICT RE-5J

DOING BUSINESS AS:

POLICY NUMBER: KAMV0000018065801 POLICY EFFECTIVE DATE: 08/01/22

POLICY ANNIVERSARY: 08/01

STATE OF ISSUE: CO

This Amendment is attached to and made part of the Policy effective 08/01/22 at 12:01 AM, Standard Time. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

It is hereby understood and agreed the Policy is renewed for a period of one year, commencing 08/01/22 and ending 08/31/23

Renewal Premium: AS REPORTED

This Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Amendment.

The President and Secretary of AXIS Insurance Company witness this Amendment:

Secretary

President

Can W. Mun