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 pages 2 and 3 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

Attach current 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.

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

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.

Applicable in 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.

Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington and West Virginia

Any person who knowingly and with intent to defraud any insurance company or another person, files a 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, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied.

Applicable in California

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Applicable in Florida and Idaho

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.*

* In Florida - Third Degree Felony

Applicable in Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she 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.

Applicable in Oklahoma

WARNING: 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.

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

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.
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. We ***MUST*** have a copy of your online confirmation page, IMR (Individual Membership Registration) form, or USA Hockey Roster to process your claim.
5. USA Hockey Insurance is an excess policy and may carry a ***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:_____

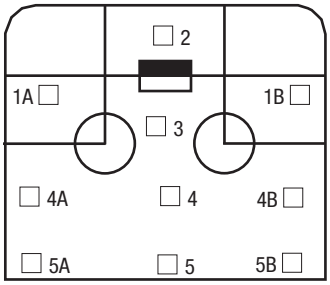
INJURY: Date of Injury:_____ Body part injured:_____
Describe nature of injury (fracture, contusion, concussion, paralysis, dislocation, sprain, etc.):_____

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:

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



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

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

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

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

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

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

1257 HC-1 REV. 2/09

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.

1257 HC-1 REV. 2/09