K&K
Insurance

SPECIALTY
BENEFITS, INC.

PROCEDURE FOR FILING A CLAIM

On behalf of Nationwide Life Insurance Company
Nationwide Mutual Insurance Company

1712 Magnavox Way
P0. Box 2338
Fort Wayne, Indiana 46801-2338
1-800-237-2917 1-260-459-5915
In Canada 1-800-753-2632
www.kandkinsurance.com

The attached claim form is to be provided to the parents and/or the claimant by the insurance coordinator.

• The insurance coordinator must complete the bottom portion of the claim form.
• The remainder of the form (Proof of Loss) is to be completed, and signed, by the parent/guardian/claimant.

If you have any questions regarding the filing of a claim, please contact our Claims Department at 1 -800-237-2917.

INSTRUCTIONS FOR INSURANCE COORDINATOR

• You must indicate the name of the team, league and/or association on the claim form. This information is found on the Certificate of Insurance in the upper left-hand corner.

• Please complete the bottom portion of the claim form in its entirety.

INSTRUCTIONS FOR PARENTS

• Please be advised that this coverage is subject to a $100 deductible and is excess/secondary to any other valid and collectible coverage available to the claimant. This means that if there is other health and/or accident coverage available, all charges must be submitted to them first on a primary basis. Subject to the terms and conditions of this policy, coverage will apply to the amount not covered by other insurance. If you have other coverage, the other carrier's payment(s) will be used to satisfy the deductible under this policy. If you have no other coverage, we will apply the $100 deductible to the charges received until the deductible has been satisfied.

• You are responsible for completing the upper portion of the claim form. Omission of any information may cause a delay in the processing of your claim.

• Only expenses incurred within 104 weeks from the date of accident will be considered.

• If you have coverage under an HMO plan, but do not seek treatment from a provider within that plan, your benefits under this policy may be reduced by the amount that would have been paid had the services been provided by a provider within your HMO plan. You would also be responsible for the deductible under this plan.

• Attach all itemized charges along with the explanation of benefits from any other insurance showing what has, or has not, been paid. We will then process the outstanding portion of your claim in accordance with the terms and conditions of this policy.

• Verify that the insurance coordinator has completed the lower portion of the claim form in its entirety.

Claims Department
P.O. Box 2338
Fort Wayne, IN 46801
1-800-237-2917

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

AMATEUR SPORTS ACCIDENT INSURANCE CLAIM FORM

on behalf of Nationwide Life Insurance Company
and Nationwide Mutual Insurance Company

PROOF OF LOSS · TO BE COMPLETED BY PARTICIPANT OR PARENT

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THE CLAIM FORM BE PROVIDED. OMISSION OF VITAL INFORMATION WILL RESULT IN DELAYS IN CLAIM PROCESSING.

Name of injured person:______________________________ Date of birth:______________

Address:____
Street City State Zip

Home phone:______________________ Work phone:______________________

Date injury occurred:______________________ Sport covered:______________________
Month / Day / Year

Location and description of how injury occurred:______________________________

INJURED - CHECK ONE: ❑ Player ❑ Coach ❑ Official ❑ Spectator ❑ Other Nature of injury:______________

COVERAGE UNDER THIS SPORTS POLICY IS EXCESS OVER ALL OTHER INSURANCE. THIS MEANS THAT YOUR CLAIM FOR INJURY SHOULD FIRST BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR PERSONAL HEALTH PLAN, YOUR EMPLOYER, YOUR SPOUSE'S EMPLOYER OR THROUGH SOME GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCES HAVE PAID THEIR BENEFITS, YOU SHOULD NOTIFY US OF BENEFITS PAID. IF YOU BELIEVE YOUR OTHER COVERAGE WILL NOT PROVIDE BENEFITS, SEND US **A COPY OF ITEMIZED CHARGES AND PROOF OF DENIAL AND/OR PAYMENT.** COVERED EXPENSES ARE SUBJECT TO $100 PER CLAIM DEDUCTIBLE. ONLY EXPENSES INCURRED WITHIN 104 WEEKS FROM THE DATE OF THE ACCIDENT WILL BE CONSIDERED.

WE WILL BE UNABLE TO PROCESS YOUR CLAIM WITHOUT THE EMPLOYER INFORMATION, EVEN THOUGH YOU MAY BELIEVE THERE IS NO OTHER COVERAGE. THE DATA REQUESTED IS IMPERATIVE AND WILL EXPEDITE YOUR CLAIM PROCESSING.

INJURED PERSON:______________________
(or parent if injured person is a minor)

EMPLOYER NAME:______________________

EMPLOYER ADDRESS:______________________

____

PHONE:__________ POLICY NO:__________

GROUP INSURANCE COMPANY:______________________

INSURANCE COMPANY ADDRESS:______________________

❑ YES – CLAIMANT IS COVERED BY THIS POLICY

❑ NO – CLAIMANT IS NOT COVERED BY THIS POLICY

SPOUSE'S NAME:______________________
(or parent if injured person is a minor)

EMPLOYER NAME:______________________

EMPLOYER ADDRESS:______________________

____

PHONE:__________ POLICY NO:__________

GROUP INSURANCE COMPANY:______________________

INSURANCE COMPANY ADDRESS:______________________

❑ YES – CLAIMANT IS COVERED BY THIS POLICY

❑ NO – CLAIMANT IS NOT COVERED BY THIS POLICY

AUTHORIZATION

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K CLAIM SERVICE 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 CLAIM SERVICE 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 PHOTO COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

(THE ABOVE PARAGRAPHS ARE BEING USED IN ORDER TO FACILITATE OUR OBTAINING AND PROVIDING PROPER INFORMATION NEEDED TO QUICKLY PROCESS YOUR CLAIM.)

I CERTIFY THAT ALL THE FOREGOING STATEMENTS AND ANSWERS ON THIS FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE ______________________ DATE ______________________

PLEASE NOTE: IF INJURED PERSON IS A MINOR, SIGNATURE MUST BE OF PARENT OR LEGAL GUARDIAN.

TO BE COMPLETED BY SPORTS PROGRAM INSURANCE COORDINATOR

SPORTS PROGRAM REPRESENTATIVE'S CERTIFICATION

I hereby certify that the person named below was insured for the activity in which the injury occurred and that the premium was paid prior to the date of injury.

Full name of sports organization:______________________ Policy number:______________

Mailing address:____
Street City State Zip

Printed name of official:____

Authorized signature:______________________ Date:______________

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