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How to File a Medical Claim

Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy.
Please forward claims and questions to the following address:

K&K Insurance / Specialty Benefits, Inc.
P.O. Box 2338, Fort Wayne, IN 46801
Toll Free Number: (800)-237-2917, option 1 • Fax Number: (312)-381-9077 • kk.PAClaims@kandkinsurance.com

Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail

The Policyholder (Coach or Tournament Director) not the Parent, Claimant or Agent should:

- Fully answer/sign each item in the Policyholder Certification section which includes the Team's Certificate Number. Claims submitted without complete information will be returned.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

The Parent/Guardian or Adult Claimant should:

- Fully answer/sign each item in the Claimant Certification section (choose either the Parent/Guardian column or the Adult Claimant column; which ever is applicable).
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

Step 2 - Submit itemized medical bills for payment consideration to our office. Also include any other insurance carrier's corresponding Explanation of Benefits (EOBs). If you have other insurance, provide the hospitals and doctors our contact information so they will bill us after receiving payment from your other insurance.

Helpful information for submitting claims and expediting payment

- A fully completed Notice of Claim is required for each accident/injury a Claimant incurs. Claims submitted with incomplete information will be denied pending receipt of the missing data.
- Release of claim forms by an insurance company is not an admission of coverage. In addition, information on the form is subject to audit by the insurance company.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.
- Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

K&K INSURANCE

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

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

Notice of Claim

THE HARTFORD

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K&K Insurance / Specialty Benefits, Inc. P.O. Box 2338, Fort Wayne, IN 46801
Toll Free Number: (800)-237-2917, option 1 • Fax Number: (312)-381-9077 • kk.PAClaims@kandkinsurance.com

POLICYHOLDER CERTIFICATION - To be completed by Policyholder (Coach or Tournament Director).

**For identification purposes, all claims must include the Certificate Number or a copy of the Liability Certificate*

ID Number 36-SB-206413 Team Name Lakewood Junior Baseball Association Certificate Number * RPG-BB-11-001222

Policyholder Name RPG Coach or Tournament Director's Phone Number ( )

Policyholder Address (Street, City, State & Zip Code) , VA

Claimant is registered: ❑ Player ❑ Manager ❑ Coach ❑ Umpire/Official ❑ Other

Claimant (Injured Party) Name

Indicate injured body part(s) ❑ Right ❑ Left

Place of Accident

Date of Accident (mm/dd/yyyy) Time of Accident (hh:mm) ❑ AM ❑ PM

If this event was sanctioned by another sports organization, please list here

Policyholder Certification Signature Required:

I hereby certify the Claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity. I further certify I have **read and signed** the Fraud Warning Statement located on the reverse side of this form. Please note, if the injury happened to a Coach or Tournament Direct or or to his/her child, please have a **non family member** Policyholder Official sign this form.

Policyholder Signature (Coach or Tournament Director) Date

CLAIMANT CERTIFICATION - To be completed by Parent/Guardian or Adult Claimant.

*** Due to new government regulations, claims submitted without complete data will be returned.*

Parent/Guardian completes for dependent child

Claimant (Dependent child) Name

Claimant Date of Birth ❑ Male ❑ Female

Claimant Social Security Number**

Claimant Address *(Street Number, City, State, Zip)*

Other Insurance Information:

Is Claimant insured by Parent /Guardian's employers medical policy? ❑ Yes ❑ No

If Yes, please forward Provider's medical bill and your other insurance carrier's corresponding Explanation of Benefits (EOB) to our office ***at the same time.*** *Submitting one item without the other will only delay claim review.*

Is Claimant a Medicare Beneficiary? ❑ Yes ❑ No

Is Claimant a Medicaid Beneficiary? ❑ Yes ❑ No

Is Claimant insured by another policy? ❑ Yes ❑ No

Are you a member of any other sports organization that would provide coverage for this injury? ❑ Yes ❑ No Organization

Adult Claimant completes

Claimant Name

Claimant Date of Birth ❑ Male ❑ Female

Claimant Social Security Number**

Claimant Address *(Street Number, City, State, Zip)*

Other Insurance Information:

Are you insured through your/spouse's employers medical policy ? ❑ Yes ❑ No

If Yes, please forward Provider's medical bill and your other insurance carrier's corresponding Explanation of Benefits (EOB) to our office ***at the same time.*** *Submitting one item without the other will only delay claim review.*

Is Claimant a Medicare Beneficiary? ❑ Yes ❑ No

Is Claimant a Medicaid Beneficiary? ❑ Yes ❑ No

Is Claimant insured by another policy? ❑ Yes ❑ No

Are you a member of any other sports organization that would provide coverage for this injury? ❑ Yes ❑ No Organization

Parent/Guardian or Adult Claimant Certification Signature Required:

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have **read and signed** the Fraud Warning Certification statement located on the reverse side of this form. I also authorize any physician/hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

Printed Name Parent/Guardian or Adult Claimant Date

Signature Parent/Guardian or Adult Claimant Date

FRAUD WARNING CERTIFICATION

Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT 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 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 Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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 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 benefit 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 criminal prosecution.

Signature of Policyholder Official _____ Date _____

Signature of Parent/Guardian or Adult Claimant _____ Date _____