

Signature of State Association / Nationwide affiliate verification officer: _____

Date: _____

CLAIM PROCEDURE: U.S.A.S.A. SPECIAL RISK ACCIDENT CLAIM FORM Please print or type.

- Participant (or legal guardian if under the age of 18) must complete this form in its entirety or it may be returned to you by the U.S.A.S.A. State Association/Nationwide affiliate.
- Do not delay submitting this claim form.** This form must be received, with or without attachments, within 90 days from the date of the accident, or benefits may be denied due to untimely filing. It must be completed in its entirety. Answer every section.
- Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your U.S.A.S.A. State Association/Nationwide affiliate office for validating.
- Once the U.S.A.S.A. State Association/Nationwide affiliate has validated your claim, they will **forward it to USASA National Office** to preview and forward to the insurance company. The insurance company will inform you of any additional information they may need to process your claim.



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

DG
DES CHAMPS, GREGORY & HAYES, INC.
INSURORS



**U.S.A.S.A.
SPECIAL RISK
ACCIDENT
CLAIM FORM**

- COMPLETE THIS FORM.**
- ATTACH ALL BILLS.**
- MAIL TO: State Verification/Nationwide affiliate officer below**

IF PARTS A and B ARE NOT COMPLETED IN FULL, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

PART A – This section MUST be completed, dated and signed by the Injured Person – or by his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.

1. Name of Injured Person (Insured): *First /Middle/Last*

1a. Date of Accident: *Mo/Day/Year*

2. Complete Mailing Address: *Street/City/State/Zip*

3. Area Code/Home Ph#:

3a. Area Code/Work Ph#:

3b. Email Address:

4. Is the injured person a Medicare/Medicaid beneficiary? Yes No

4a. If Yes, please provide Social Security number or Health I.D. number: _____

5. Date of Birth: *Mo/Day/Year*

6. Male Female

6a. Single Married Full-time Student

7. Are you currently enrolled in any health insurance and/or other soccer accident plan? Yes No

If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.

Company Name: _____ Group Name: _____ Policy Number: _____

Company Name: _____ Group Name: _____ Policy Number: _____

7a. If you are not enrolled in any health insurance plan, we require written verification from your employer and your spouse's employer (if applicable), or Bursar's office if you are a full-time college student.

7b. If you are self-employed or unemployed and not covered under any health insurance plan, please sign below.

Signature of Player: _____

PART B - This section MUST be completed in full, then signed by an official of your local organization.

1. Team name:

1a. League name:

2. State Association/Nationwide affiliate:

2a. Region:

3. Injury occurred at: Game Practice Travel Other Event

4. Name and type of event:

4a. Injury occurred on: Indoor Field Outdoor Field

5. Describe how accident occurred (*example: tackled from behind, tripped and fell, collision with player, etc.*):

6. Type of injury (*example: broken arm, sprained ankle, broken nose, etc.*):

6a. Body part injured (*example: ankle, knee, shoulder, head, etc.*):

7. Name and Phone Number of coach, manager or referee present at the time of the accident:

8. *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 League Verification Officer: _____

Title: _____

Signature of USASA Verification Officer: _____

Title: _____

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 hereby 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 and 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 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 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 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.

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.

**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**

