



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

# 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: \_\_\_\_\_

Location & Description of how injury occurred: \_\_\_\_\_  
Month / Day / Year

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.

MOTHER/INJURED PERSON \_\_\_\_\_

FATHER/SPOUSE \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ POLICY NO. \_\_\_\_\_

PHONE \_\_\_\_\_ POLICY NO. \_\_\_\_\_

GROUP INSURANCE COMPANY \_\_\_\_\_

GROUP INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

YES – CLAIMANT IS COVERED BY THIS POLICY

YES – CLAIMANT IS COVERED BY THIS POLICY

NO – CLAIMANT IS NOT 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: \_\_\_\_\_

Dear Sports Participant: If you have an appointment with a doctor as the result of a sports 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 Benefits 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.

---

### **Arkansas, Florida, Kentucky, Michigan, New Jersey and Pennsylvania**

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 civil penalties.

### **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. California Insurance Frauds Prevention Act 1871.2

### **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 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.

### **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.

### **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.

### **Minnesota**

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

### **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.

### **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.

### **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 or 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.

### **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.

### **Oklahoma**

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. (360.S. 5361.1)