



1712 Magnavox Way P.O. Box 2338  
 Fort Wayne, Indiana 46801  
 ph (800) 237-2917  
 Fax (260) 459-5915 for Participant Accident Unit  
 http://www.kandkinsurance.com

# Catholic Mutual INCIDENT REPORT

On behalf of Nationwide Insurance

**(PLEASE PRINT)**

<b>INSURED</b>	NAME OF INSURED: _____ POLICY#: _____ PARISH/SCHOOL: _____ CITY/STATE: _____
<b>TIME &amp; PLACE OF INCIDENT</b>	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM ACTIVITY: _____ EVENT TYPE: _____ LOCATION: _____
<b>HAPPENED TO</b>	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: (____) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
<b>FUNCTION</b>	AS: <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER: _____
<b>APPARENT INJURY OR DAMAGE</b>	BODY PART: _____ CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY
<b>OCCASION</b>	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____
<b>INCIDENT DESCRIPTION</b>	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____
<b>WITNESSES</b> (If known)	NAME: _____ NAME: _____ ADDRESS: _____ ADDRESS: _____ PHONE: (____) _____ PHONE: (____) _____
<b>PASTOR/PARISH/SCHOOL ADMINISTRATOR</b>	NAME: _____ PHONE: (____) _____ TITLE: _____ ORGANIZATION: _____ SIGNATURE: _____ DATE: _____

**COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:  
 K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338  
 THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE  
 BEFORE RETURNING OR PROCESSING MAY BE DELAYED**



# Catholic Mutual PARTICIPANT ACCIDENT INSURANCE CLAIM FORM

*(NOTE To the Participant/Parent/Guardian: Report and Claim Form will be returned if not fully completed and signed.)*

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## Basic Procedures for Submitting the Incident Report and Participant Accident Insurance Claim Form

1. The Parish/School Administrator or Pastor will complete the incident report, sign and date where indicated, and give the form to the participant.
  2. The participant or participant's parents/guardian will complete the Accident Medical/Insurance Claim form, and forward it to K&K Insurance Group, Inc.
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### To the Participant/Parent/Guardian:

Attach current itemized physician, hospital, or other provider's bills for accident medical expenses being claimed as well as the primary carrier's Explanation of Benefits showing their 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.

MAIL TO:  
**K&K INSURANCE GROUP, INC.**  
Claims Department  
P.O. Box 2338  
Fort Wayne, Indiana 46801-2338  
(800) 237-2917

**For general claims questions or status of a claim call:**  
800-237-2917, option 1. or efax: 312-381-9077



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Fort Wayne, Indiana 46801
(800) 237-2917 Fax (260) 459-5915
email: KK\_PAClaims@kandkinsurance.com
http://www.kandkinsurance.com

Catholic Mutual
ACCIDENT MEDICAL INSURANCE
CLAIM FORM

Insured Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED.
OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.
TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

MEDICAL BENEFITS UNDER THIS POLICY MAY PROVIDE PRIMARY, EXCESS OR A COMBINATION OF BOTH COVERAGES. UPON RECEIPT OF THIS CLAIM FORM , AN
ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

IF THE MEDICAL BENEFIT IS EXCESS, YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S
PERSONAL 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.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED
INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON: \_\_\_\_\_ SPOUSE'S NAME (if applicable): \_\_\_\_\_

FATHER'S NAME (if injured is a minor) \_\_\_\_\_ MOTHER'S NAME (if injured is a minor) \_\_\_\_\_

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

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

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

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

POLICY NUMBER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

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

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

SIGNATURE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K 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 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 INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

**APPLICABLE IN ALASKA**

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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, KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, SOUTH DAKOTA, TENNESSEE, TEXAS, VIRGINIA, 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 LA, ME, TN, and VA, 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 THE DISTRICT OF COLUMBIA**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines.

**APPLICABLE IN FLORIDA**

Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or S. 775.084, Florida Statutes.

**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 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.

**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 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.

**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.

**APPLICABLE IN RHODE ISLAND**

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.

**APPLICABLE IN 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 include imprisonment, fines and denial of insurance benefits.

FRAUD CLAIMS (2010/02)

Dear Participant: If you have an appointment with a doctor as the result of a sport related 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 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.