U.S. ALL STAR FEDERATION

Incident Report & Participant Accident Claim Form Instructions

(NOTE: Report and Claim Form will be returned if not fully completed and signed.)

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

1. If the claim involves injury to a spectator or property damage, only PART I needs to be completed by the School/Club and sent to K&K Insurance Group, Inc.

2. The USASF School/Club owner, instructor or coach will complete PART I.

3. If the injured party was a USASF Member student/participant, the student's parents/guardian will completed PART II and forward it with PART I to K&K Insurance Group, Inc.

To the Athlete/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.

If you have no other insurance give the medical providers the K&K information below for billing. If you do have other insurance, give the medical providers your other insurance information as your primary insurance and the K&K information below as your secondary insurance. If this procedure is followed, the medical provider will automatically bill K&K for any balance remaining after the primary insurance has processed.

Mail To:

K&K INSURANCE GROUP, INC.

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

Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917
Fax (312) 381-9077
email: KK.PAClaims@kandkinsurance.com

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
email: KK.PAClaims@kandkinsurance.com
http://www.kandkinsurance.com
on behalf of Nationwide Mutual Insurance Company & Nationwide Life Insurance Company

U.S. ALL STAR USASF FEDERATION FOR CHEER & DANCE TEAMS

INCIDENT REPORT

Use this form for ANY injury to athlete as well as spectator

(PLEASE PRINT)

PART I

NATURE ❑ BODILY INJURY ❑ PROPERTY DAMAGE ❑ OTHER:_____

TIME & PLACE OF INCIDENT
DATE:_____ TIME:_____ ❑ AM ❑ PM
EVENT/ACTIVITY NAME:_____
EVENT/ACTIVITY TYPE:_____ SANCTIONED BY:_____
LOCATION:_____

HAPPENED TO
NAME:_____ SSN:_____
DATE OF BIRTH: _____ SEX: ❑ Male ❑ Female PHONE: (_____)_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
USASF ATHLETE MEMBER? ❑ YES ❑ NO LEVEL: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 4.2 ❑ 5 ❑ 6

FUNCTION
AS: ❑ CHEERLEADER ❑ DANCER ❑ VOLUNTEER ❑ SPECTATOR ❑ PARENT ❑ OFFICIAL ❑ NONMEMBER/GUEST
❑ OTHER:_____

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.):_____
❑ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:_____
❑ AMBULANCE, TAKEN TO:_____ CITY:_____
❑ FATALITY ❑ REFUSED TREATMENT ❑ OTHER_____

LOCATION:
- ❑ SPECTATOR AREA
- ❑ TRAMPOLINE
- ❑ FOAM PIT
- ❑ PARTY ROOM
- ❑ PARKING AREA
- ❑ OPEN FLOOR
- ❑ INFLATABLES
- ❑ FLOOR EXERCISE
- ❑ COMPETITION AREA NONSPECIFIC
- ❑ OTHER:_____

OCCASION:
- ❑ SANCTIONED COMPETITION
- ❑ UNSPECIFIED
- ❑ TRYOUTS
- ❑ TRAINING CAMP
- ❑ TO/FROM EVENT
- ❑ DURING PRACTICE
- ❑ NON-SANCTIONED EVENT
- ❑ BEFORE PRACTICE
- ❑ AFTER PRACTICE
- ❑ BEFORE EVENT
- ❑ AFTER EVENT

TYPE:
- ❑ STANDING TUMBLING
- ❑ RUNNING TUMBLING
- ❑ STUNT
- ❑ PYRAMID
- ❑ TOSS
- ❑ DISMOUNT
- ❑ JUMPS
- ❑ DANCING/CHEERING
- ❑ SPOTTING/CATCHING
- ❑ OTHER:_____

SURFACE:
- ❑ TRAMPOLINE BED
- ❑ SPRING BOARD
- ❑ SOLID FOAM PIT
- ❑ MAT
- ❑ SPRING FLOOR
- ❑ TUMBLE TRAK
- ❑ OTHER:_____

SITUATION:
- ❑ TRIPPED
- ❑ COLLISION W/ PERSON
- ❑ COLLISION W/ PARTICIPANT
- ❑ FELL
- ❑ FELL, LANDED WRONG
- ❑ FELL, UNEVEN SURFACE
- ❑ FELL ON BY PARTICIPANT
- ❑ HIT BY PARTICIPANT
- ❑ DIZZY/FELL
- ❑ KICKED
- ❑ LANDED WRONG
- ❑ OVER-ROTATED
- ❑ RAN INTO OBJECT
- ❑ THROWN/LANDED WRONG
- ❑ TRAMPOLINE ACCIDENT
- ❑ OTHER_____

PROGRAM:
- ❑ GYM PRACTICE
- ❑ GYM COMPETITION/EVENT
- ❑ GYM CAMP/CLINIC
- ❑ GYM PARTY
- ❑ OPEN GYM
- ❑ OFF PREMISES COMPETITION-SANCTIONED
- ❑ OFF PREMISES COMPETITION-NONSANCTIONED
- ❑ OFF PREMISES PRACTICE

INCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED:_____

WITNESSES (If known)
NAME:_____ NAME:_____
ADDRESS:_____ ADDRESS:_____
PHONE: (_____)_____ PHONE: (_____)_____

INSURED/GYM
SCHOOL/CLUB NAME OF INSURED:_____ POLICY#:_____
SCHOOL/CLUB NAME:_____ PHONE: (_____)_____
CITY:_____ STATE:_____
SCHOOL/CLUB #:_____

INSURED REPRESENTATIVE
❑ COACH ❑ OFFICIAL ❑ TRAINER ❑ PROMOTER ❑ TEAM/LEAGUE REPRESENTATIVE ❑ OTHER:_____
NAME:_____ PHONE: (_____)_____
TITLE:_____ SCHOOL/CLUB #:_____
SCHOOL/CLUB NAME:_____
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 SCHOOL/CLUB NAME AND SCHOOL/CLUB NUMBER, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
(800) 237-2917 Fax (312) 381-9077
email: KK.PAClaims@kandkinsurance.com
http://www.kandkinsurance.com

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

U.S. ALL STAR USASF FEDERATION FOR CHEER & DANCE TEAMS

PARTICIPANT ACCIDENT CLAIM FORM

School/Club Name:_____

School/Club Number:_____

If the injured participant is a USASF Member Athlete, has this claim also been submitted under the Athlete Member Insurance Program? ❑ YES ❑ NO

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

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER INSURANCE AND HAS A **$250.00 DEDUCTIBLE PER CLAIM** AND IS LIMITED TO THOSE EXPENSES INCURRED WITHIN 104 WEEKS FROM THE DATE OF THE ACCIDENT. THIS COVERAGE IS IN EXCESS OF ANY OTHER VALID AND COLLECTIBLE HEALTH & ACCIDENT INSURANCE. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR 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. IF THERE IS NO OTHER INSURANCE, THE POLICY WILL ACT AS PRIMARY INSURANCE.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. THE DATA REQUESTED IS IMPERATIVE AND WILL SPEED UP YOUR CLAIM PROCESSING.

INJURED PERSON:_____

FATHER'S NAME (if injured is a minor)_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

GROUP INSURANCE COMPANY:_____

POLICY NUMBER:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY NUMBER:_____

SIGNATURE:_____

SPOUSE'S NAME (if applicable):_____

MOTHER'S NAME (if injured is a minor)_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

GROUP INSURANCE COMPANY:_____

POLICY NUMBER:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY NUMBER:_____

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 ALABAMA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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, RHODE ISLAND, 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. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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 KANSAS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN 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.

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 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 (2013/01)

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:

The First Health Network

HYGEIA

PHCS

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.