



**AMERICAN LEGION BASEBALL**

**2022**  
**Claim Reporting**  
**Information**



1712 Magnavox Way PO Box 2338  
Fort Wayne, IN 46801-2338  
Phone: (800)237-2917  
Fax: Property & Casualty (312) 381-9079  
Fax: Participant Accident (312) 381-9077  
www.kandkinsurance.com CA #0334819

# INCIDENT REPORTING INSTRUCTIONS & EMERGENCY PROCEDURES

## EMERGENCY PROCEDURES

1. **ACTION:** Follow your written plan and take appropriate care of all injured persons.
2. **NOTICE:** Incidents can happen anywhere. Advising K&K as soon as practical after an incident occurs surrounding your event, regardless of the location of the incident or whether or not you feel you are responsible for the bodily injury or property damage, is essential. If appropriate, an adjuster will be assigned immediately.
3. **STATEMENT:** Do not make any statements regarding the cause of the accident. Give no opinions or conjectures to anyone other than your insurance company representative.  
**DO NOT ADMIT TO LIABILITY. DO NOT INFER OR PROMISE TO PAY. Use only the acceptable statement: "The accident is under investigation," NOTHING MORE!**
4. **INVESTIGATION:** Cooperate with your insurance company representative. Let this person make any and all conclusive investigations.
5. **WITNESSES:** Secure names, addresses and phone numbers (home and work) of witnesses as soon as possible after the accident. **NOTHING MORE!**
6. **WAIVER & RELEASE:** (If required) If insured person was in restricted area, locate signed Waiver and Release immediately and store in safe place. Send to the insurance company only by request and by registered mail. Retain photocopy of Waiver and Release for your file.
7. **LOCAL AUTHORITIES:** If the incident is investigated by local authorities, identify to K&K i.e. police, from what town, county and state.
8. **INCIDENT REPORT FORM:** Complete all information required and available within 24 hours. Minimum information should include facility name and address, date of accident, victim's name, address and phone number; family name and phone number if fatality; and the signature of the person that completed form.

**Mail ASAP – nothing can be handled by the insuring company without this information.**

**REMEMBER: NOTIFY K&K OF ALL INCIDENTS,  
NOT JUST THOSE CATASTROPHIC IN NATURE.**

## PREPARE FOR EMERGENCIES

1. Have a qualified person designated to make ALL private, public or media statements. Make all personnel aware that only the designated statement person inquires about a loss.
2. Make a separate qualified person designated for all emergency medical, fire and security operations.
3. Have adequate personnel on site: security, medical, and fire protection services and equipment. "Adequate" means proper and prudent for your anticipated attendance and event activity.
4. Have backup personnel and equipment, including backup power sources, in place to maintain event integrity.
5. Have a written crisis management plan that addresses all "worst scenario" situations, including evacuation.
6. Train and practice all emergency procedures.
7. If policy wording requires it, have adequate supplies of Waiver and Release forms. Have adequate accident reporting forms on site. Those who must sign a Waiver and Release form are those persons practicing and/or participating in any athletic event sponsored by you, as well as anyone entering a restricted area, which is generally defined as any area where admittance to the general public is prohibited.
8. Have the name and number of your Insurance Contact posted prominently. In case of a major spectator loss or fatality, K&K's 24-hour number is 260-459-5000. Have one person responsible for this call. Call K&K direct; do not rely on a Broker, etc. to relay the call.



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

# K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE	<input type="radio"/> BODILY INJURY <input type="radio"/> PROPERTY DAMAGE: <input type="radio"/> OTHER: _____							
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="radio"/> AM <input type="radio"/> PM EVENT NAME: _____ EVENT TYPE: _____ SANCTIONED BY: _____ LOCATION: _____							
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="radio"/> Male <input type="radio"/> Female    PHONE: (____) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____							
FUNCTION	AS: <input type="radio"/> ATHLETE <input type="radio"/> PARTICIPANT <input type="radio"/> VOLUNTEER <input type="radio"/> SPECTATOR <input type="radio"/> BYSTANDER <input type="radio"/> OFFICIAL <input type="radio"/> OTHER: _____							
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____ <input type="radio"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER)    OTHER: _____ <input type="radio"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="radio"/> FATALITY							
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____							
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____							
WITNESSES (If known)	<table border="0" style="width:100%"> <tr> <td style="width:50%">NAME: _____</td> <td style="width:50%">NAME: _____</td> </tr> <tr> <td>ADDRESS: _____</td> <td>ADDRESS: _____</td> </tr> <tr> <td>PHONE: (____) _____</td> <td>PHONE: (____) _____</td> </tr> </table>		NAME: _____	NAME: _____	ADDRESS: _____	ADDRESS: _____	PHONE: (____) _____	PHONE: (____) _____
NAME: _____	NAME: _____							
ADDRESS: _____	ADDRESS: _____							
PHONE: (____) _____	PHONE: (____) _____							
INSURED	NAME OF INSURED: _____ POLICY #: _____ CLUB NAME: _____ PHONE: (____) _____ CITY: _____ STATE: _____							
INSURED REPRESENTATIVE	<input type="radio"/> COACH <input type="radio"/> OFFICIAL <input type="radio"/> TRAINER <input type="radio"/> PROMOTER <input type="radio"/> TEAM/LEAGUE REPRESENTATIVE <input type="radio"/> OTHER: _____ 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



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

# PARTICIPANT ACCIDENT PRIMARY INSURANCE 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: \_\_\_\_\_  
 FATHER'S NAME (if injured is a minor): \_\_\_\_\_  
 EMPLOYER NAME: \_\_\_\_\_  
 EMPLOYER ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: (\_\_\_\_) \_\_\_\_\_

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: \_\_\_\_\_

GROUP INSURANCE COMPANY: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 INSURANCE COMPANY ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

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

**QUESTIONS REGARDING INCOME ARE ONLY APPLICABLE IF POLICY AFFORDS WEEKLY INDEMNITY BENEFITS.**

REGULAR WEEKLY INCOME: \_\_\_\_\_  
 ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME WORK? \_\_\_\_\_

INCOME LOST PER WEEK DUE TO INJURY: \_\_\_\_\_  
 ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME RACING AND/OR PARTICIPATE IN A RACING EVENT? \_\_\_\_\_

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.**



# **PARTICIPANT ACCIDENT PRIMARY INSURANCE FORM INSTRUCTIONS**

(NOTE To the Participant/Parent/Guardian: 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. The insurance coordinator, coach or league representative, official, trainer, promoter will complete the incident report (front). If the policy provides accident medical coverage and the injured party was an event participant, the form should be given to the participant or parents to complete the participant accident medical insurance claim form (Part II).
  2. The participant or participant's parents/guardian will complete the form, detach it from the instruction page, and forward it to K&K Insurance Group, Inc.
  3. **IF CLAIM INVOLVES INJURY TO A SPECTATOR OR PROPERTY DAMAGE, ONLY THE INCIDENT REPORT NEED BE COMPLETED.**
- 

### **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**

