AMERICAN LEGION BASEBALL

2025 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.

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email: KK_PAClaims@kandkinsurance.com
http://www.kandkinsurance.com

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE
O BODILY INJURY O PROPERTY DAMAGE: O OTHER: _____

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

HAPPENED TO
NAME: _____ SSN: _____
DATE OF BIRTH: _____ SEX: O Male O Female PHONE: (____) _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

FUNCTION
AS: O ATHLETE O PARTICIPANT O VOLUNTEER O SPECTATOR O BYSTANDER O OFFICIAL
O OTHER: _____

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

OCCASION
WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____

INCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED: _____

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

INSURED
NAME OF INSURED: _____ POLICY #: _____
CLUB NAME: _____ PHONE: (____) _____
CITY: _____ STATE: _____

INSURED REPRESENTATIVE
O COACH O OFFICIAL O TRAINER O PROMOTER O TEAM/LEAGUE REPRESENTATIVE O 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

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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: (_____) _____

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: _____

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 if 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.

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