POP WARNER CLAIM SUBMISSION PROCESS

Excess Medical

Pop Warner Little Scholars, Inc. provides excess accident coverage for registered participants through Hartford Life and Accident Insurance Company. The excess policy covers accidents that occur during sponsored activities and is secondary to the participants' group medical insurance.

When a player is injured, all medical bills must first be submitted to the primary insurance. As soon as possible after an accident, the injured player, or parents, if the player is a minor, will need to complete a claim form. The claim form can be obtained by downloading from the website www.popwarner.com or by calling K&K Insurance Group at 800-441-3994.

A representative of the league, coach or league official, must complete and sign the incident report section of the claim form. This is for verification purposes to confirm that the player was injured while participating in a sponsored event. The injured player, or parent, must complete Part II (Accident Medical Section). Please submit the completed Pop Warner form as soon after the injury as possible.

Once response is received from any primary insurance, please submit each itemized medical bill (a balance due statement is not sufficient) along with the corresponding primary insurance Explanation of Benefits (EOB) for each bill. If the injured player has no other insurance, that information must be noted on the claim form. The Excess Medical insurance policy becomes primary in the absence of other valid insurance.

If you require a(n) additional claim form(s), you may submit a photocopy of the blank original form or you may go to www.popwarner.com.

General Liability and Property

When an accident occurs a notice must be completed immediately. This holds true whether the person involved is a participant or a spectator, or whether or not you feel the incident will result in a claim.
To obtain a General Liability or Property Notice of Occurrence/ Claim form, please contact Beth Dietz at Pop Warner at 215-752-2691, ext. 122.

PLEASE SEE ATTACHED CLAIM FORM

K&K INSURANCE

PARTICIPANT ACCIDENT INSURANCE CLAIM FORM

(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 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

ACCIDENT MEDICAL INSURANCE CLAIM FORM

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 HEALTH & ACCIDENT INSURANCE AVAILABLE. 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. IF THERE IS NO OTHER INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. NOTE: COVERAGE MAY ALSO INCLUDE A POLICY DEDUCTIBLE.

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.

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
(800) 237-2917 Fax (260) 459-5910
http://www.kandkinsurance.com

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE	❑ BODILY INJURY ❑ PROPERTY DAMAGE ❑ OTHER:_____
TIME & PLACE OF INCIDENT	DATE:_____ TIME:_____ ❑ AM ❑ PM EVENT:_____ SPORT:_____ SANCTIONED BY:_____ LOCATION:_____
HAPPENED TO	NAME:_____ AGE:_____ SEX: ❑ Male ❑ Female PHONE:(____)_____ ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
FUNCTION	AS: ❑ PARTICIPANT ❑ VOLUNTEER ❑ SPECTATOR ❑ BYSTANDER ❑ OFFICIAL ❑ 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
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT?_____
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED:_____
WITNESSES	NAME:_____ NAME:_____ ADDRESS:_____ ADDRESS:_____ PHONE:_____ PHONE:(____)_____
INSURED	NAME OF INSURED: Pop Warner Little Scholars POLICY#:_____ CLUB NAME:_____ CITY/STATE:_____
COACH/OFFICIAL/ TEAM OR LEAGUE REPRESENTATIVE	NAME:_____ PHONE:(____)_____ TITLE:_____ ORGANIZATION:_____ SIGNATURE:_____ DATE:_____

COMPLETE ALL SECTIONS AND FAX TO (260) 459-5910 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