

August 2015

Dear Parent/Guardian,

School sports participation, like much of what our children enjoy, has some inherent risk of injury. However, the leadership of interscholastic athletics in this school district and across the state of Michigan is attempting both to provide as safe an experience as possible and enhance the health of our student-athletes.

As a part of these efforts, the Michigan High School Athletic Association provides all of its member schools with a Catastrophic Accident Medical Insurance Policy which pays up to \$500,000 for medical expenses left unpaid by other insurance after a deductible of \$25,000 per claim in paid medical expenses has been met. All students enrolled in grades 7 through 12 at MHSAA member schools who are eligible under MHSAA rules and participating in practices or competition in sports under the MHSAA's jurisdiction are covered by this policy for injuries related to their athletic participation.

Beginning with the 2015-16 school year, the Michigan High School Athletic Association is also providing eligible athletic participants at each MHSAA member junior high/middle school and high school with additional insurance that is intended to pay accident medical expense benefits resulting from a suspected concussion. The injury must be sustained while the athlete is participating in an MHSAA covered activity. Policy limit is \$25,000 for each accident. Covered students, sports and situations are identical to the catastrophic accident medical insurance which, if the \$25,000 threshold is reached, would require a separate claim to be made.

**This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 7 through 12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or under-insured. Accident medical deductibles and co-pays left unpaid by other policies are reimbursed under this program to the limits of the policy.**

Should you have need to make a claim under this new program, contact [teri.bruner@kandkinsurance.com](mailto:teri.bruner@kandkinsurance.com), or phone 800-237-2917 toll free.

Sincerely,

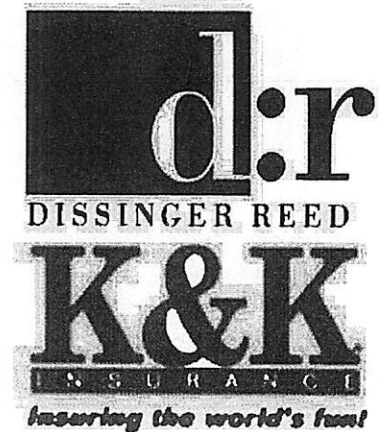
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## SUMMARY OF COVERAGE

Coverage Period: 7/01/2015 – 7/01/2016  
Carrier: Nationwide Life Insurance Company  
AM Best Rated A+ XV

### **Excess Accident Medical Limits:**

Maximum: \$ 25,000 per injury  
Usual & Customary 100%  
Benefit Period: 1 Year  
Deductible: \$0 per claim  
AD&SL \$5,000  
AD&SL Aggregate \$250,000



### **Eligible Person:**

All athletes participating in a Covered Activity.

### **Covered Activities:**

Participating in practice or play of sports governed and/or sponsored by the Participating Organization.

Participating Organization: An organization which:

1. Elects to offer coverage under the Policy by completing a Participating Organization Application that has been accepted by Us (Nationwide);
2. Completes a participation agreement with the Policyholder; and
3. Remits the required Premium when due.

### **Definition of Injury**

For the Accident medical Expense benefits, the following definition of Injury applies:

A bodily injury which is:

1. Directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under the Policy and while he or she is taking part in a Covered Activity.
3. Resulting in a concussion.

### **Definition of Concussion**

A specific brain injury defined as a complex pathophysiological process affecting the brain, induced by trauma to the brain, and diagnosed by a Physician practicing within the scope of his or her license.

## How to File a Claim

**To process your claim, please submit the following pieces of information:**

1. Completed and Signed 'K&K Incident Report'
2. Complete and Signed 'Other Insurance Questionnaire'
3. Itemized Bills
4. Explanation of Benefits from your Primary Insurance Carrier

**These documents should be mailed, emailed or faxed to:**

K&K Insurance Group  
Attn: Terri Bruner  
1712 Magnavox Way  
Fort Wayne, IN 46801

[Terri.Bruner@kandkinsurance.com](mailto:Terri.Bruner@kandkinsurance.com)

(312) 381-9077 Fax  
(800) 237-2917 Toll Free

The 'K&K Incident Report' enables the payer to open a claim for the treatment of your injury. To avoid delays in claim processing, please be sure to complete the 'Other Insurance Questionnaire'. The incident report must be signed by an MHSAA member school administrator.

Itemized Bills – please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account Statements or 'Balance Due' statements are helpful, but do not contain all the information needed to process the claim.

Explanation of Benefits – If you have other medical insurance, all medical bills first be submitted to that carrier for its determination of eligibility and payment. If the charges are not paid in full by the other medical insurance carrier, we will need to see a copy of the 'Explanation of Benefits' prior to paying any benefits. If you do not have other insurance, the need for an 'Explanation of Benefits' will not apply to your claim.





1712 Magnavox Way P.O. Box 2338  
 Fort Wayne, Indiana 46801  
 PH (800) 237-2917  
 Fax (312) 381-9077  
<http://www.kandkinsurance.com>

# K&K INCIDENT REPORT

Michigan High School Athletic Association  
 Concussion Coverage

(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> OTHER: _____
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: _____ EVENT TYPE: _____ CONDUCTED BY: _____ LOCATION: _____
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female    PHONE: (____) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> OTHER: _____
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____
OTHER SCHOOL INSURANCE	DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY: _____ _____ _____
INSURED	NAME OF INSURED: _____ POLICY#: _____ CLUB NAME: _____ PHONE: (____) _____ CITY: _____ STATE: _____
INSURED REPRESENTATIVE	<input type="checkbox"/> MHSAA Member School Administrator <input type="checkbox"/> 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



# OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: \_\_\_\_\_ INTERNATIONAL STUDENT  Yes  No  
 EMANCIPATED STUDENT:  Yes  No  
 NAME OF INSURED: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

## FATHER

## MOTHER

IS FATHER DECEASED?  Yes  No  
 IS FATHER LEGALLY RESPONSIBLE?  Yes  No  
 FATHER'S NAME (if injured is a minor) \_\_\_\_\_  
 SOCIAL SECURITY #: \_\_\_\_\_  
 EMPLOYED?  Yes  No SELF-EMPLOYED?  Yes  No  
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE?  Yes  No  
 EMPLOYER NAME: \_\_\_\_\_  
 EMPLOYER ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: (\_\_\_\_\_) \_\_\_\_\_  
 CONTACT PERSON: \_\_\_\_\_

IS MOTHER DECEASED?  Yes  No  
 IS MOTHER LEGALLY RESPONSIBLE?  Yes  No  
 MOTHER'S NAME (if injured is a minor) \_\_\_\_\_  
 SOCIAL SECURITY #: \_\_\_\_\_  
 EMPLOYED?  Yes  No SELF-EMPLOYED?  Yes  No  
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE?  Yes  No  
 EMPLOYER NAME: \_\_\_\_\_  
 EMPLOYER ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: (\_\_\_\_\_) \_\_\_\_\_  
 CONTACT PERSON: \_\_\_\_\_

Do you have group medical insurance coverage through your employment?  
 Yes  No  
 If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

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 Yes  No  
 If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY: \_\_\_\_\_  
 INSURANCE COMPANY ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 TYPE OF PLAN:  HEALTH MAINTENANCE ORGANIZATION (HMO)  
 PREFERRED PROVIDER ORGANIZATION (PPO)  
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE  
 OTHER (describe) \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_  
 INSURANCE COMPANY ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 TYPE OF PLAN:  HEALTH MAINTENANCE ORGANIZATION (HMO)  
 PREFERRED PROVIDER ORGANIZATION (PPO)  
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE  
 OTHER (describe) \_\_\_\_\_

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: \_\_\_\_\_  
 DATE: \_\_\_\_\_

PARENT/GUARDIAN/MOTHER SIGNATURE: \_\_\_\_\_  
 DATE: \_\_\_\_\_