5800 Explorer Drive, Suite 101
Mississauga ON L4W 5K9
905-602-9339 or 800-753-2632
Fax : 905-602-9141
www.kandkcanada.com
K&K Insurance Brokers, Inc. Canada

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE	❑ BODILY INJURY ▫PROPERTY DAMAGE ▫OTI
TIME & PLACE OF INCIDENT	DATE: TIME: ❑ AM ▫PM EVENT NAME: EVENT TYPE: S BY: LOCATION:
HAPPENED TO	NAME: SSN: DATE OF BIRTH: SEX: ▫Male ❑ Female PHONE: ( ) ADDRESS: CITY: STATE: ZIP:
FUNCTION	AS: ▫ATHLETE ▫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 (If known)	NAME: NAME: ADDRESS: ADDRESS: PHONE: ( ) PHONE: ( )
INSURED	NAME OF INSURED: POLICY#: CLUB NAME: (
INSURED REPRESENTATIVE	❑ COACH ▫OFFICIAL ▫TRAINER ▫PROMOTER TEAM/LEAGUE REPRESENTATIVE ▫OTHER: NAME: PHONE: ( ) TITLE: ORGANIZATION: SIGNATURE: DATE:

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

K&K INSURANCE 5800 Explorer Drive, Suite 101 Mississauga ON L4W 5K9

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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ACCIDENT MEDICAL INSURANCE CLAIM 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): _____

GROUP INSURANCE COMPANY: _____

POLICY NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER:

SIGNATURE: _____

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: _____

INCOME LOST PER WEEK DUE TO INJURY: _____

ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME WORK? _____

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 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, 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.

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