



# CLUB INSURANCE PROGRAM PARTICIPANT ACCIDENT MEDICAL CLAIM FORM

SEND COMPLETED FORM TO:  
K&K Insurance Group, Inc.  
ATTN: Claims Department  
1712 Magnavox Way, P.O. Box 2338  
Ft. Wayne, IN 46804  
312-381-9077 Facsimile  
KK\_PAClaims@kandkinsurance.com

**This form is required to submit a Participant Accident medical claim for injuries sustained during a Club activity or event.  
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.**

**NOT FOR USE WITH USA WATER SKI SANCTIONED EVENTS.**

<b>TO BE COMPLETED BY INJURED PARTY (OR BY PARENT/LEGAL GUARDIAN IN CASE OF A MINOR)</b>							
NAME (Last Name)	(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	MINOR:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE
MARRIED: <input type="checkbox"/> YES <input type="checkbox"/> NO						<input type="checkbox"/> FEMALE	
HOME ADDRESS (Street)				(City)	(State)	(Zip Code)	HOME TEL. # ( )
OCCUPATION		NAME AND ADDRESS OF EMPLOYER			EMPLOYER'S MAIN TEL. #: ( )		
NAME OF SPOUSE (IF MARRIED)		NAME AND ADDRESS OF EMPLOYER FOR SPOUSE			EMPLOYER'S MAIN TEL. #: ( )		
NAME OF PARENT/LEGAL GUARDIAN (IF MINOR)		NAME AND ADDRESS OF EMPLOYER FOR PARENT/LEGAL GUARDIAN			EMPLOYER'S MAIN TEL. #: ( )		
NAME OF PARENT/LEGAL GUARDIAN (IF MINOR)		NAME AND ADDRESS OF EMPLOYER FOR PARENT/LEGAL GUARDIAN			EMPLOYER'S MAIN TEL. #: ( )		
USA WATER SKI MEMBERSHIP STATUS: <input type="checkbox"/> ACTIVE MEMBER <input type="checkbox"/> GUEST/BASIC SKILLS MEMBER    MEMBERSHIP #: _____							
SPORT DISCIPLINE: <input type="checkbox"/> AWSA (3 Event) <input type="checkbox"/> AKA (Kneeboard) <input type="checkbox"/> NCWSA (Collegiate) <input type="checkbox"/> NWSRA (Ski Racing) <input type="checkbox"/> WSDA (Disabled) <input type="checkbox"/> ABC (Barefoot) <input type="checkbox"/> USW (Wakeboard) <input type="checkbox"/> NSSA (Show Ski) <input type="checkbox"/> USHA (Hydrofoil)							
TYPE OF CLUB ACTIVITY OR EVENT: <input type="checkbox"/> TOURNAMENT <input type="checkbox"/> PRACTICE <input type="checkbox"/> EXHIBITION <input type="checkbox"/> OFFICIALS CLINIC <input type="checkbox"/> BASIC SKILLS CLINIC <input type="checkbox"/> OTHER: _____							
DID THE INJURY OCCUR DURING A CLUB ORGANIZED EVENT?:				<input type="checkbox"/> YES <input type="checkbox"/> NO			
DID THE INJURY OCCUR WHILE TRAVELING TO/FROM THE EVENT?:				<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF EVENT:			NAME OF SAFETY/CLUB OFFICIAL OR EVENT ORGANIZER:			TEL. # ( )	
NATURE OF INJURY:			DATE OF INJURY:		TIME OF INJURY: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<b>FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:</b> A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT: _____ B. DESCRIBE WHERE ACCIDENT HAPPENED: _____ C. DESCRIBE HOW ACCIDENT HAPPENED: _____ D. WITNESS NAME: _____ TEL. #: ( )							
IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN(S), INCLUDING BUT NOT LIMITED TO: GROUP OR INDIVIDUAL MEDICAL, MEDICARE, MEDICAID OR OTHER MILITARY/GOVERNMENT PLANS, OR AUTOMOBILE PLAN? <input type="checkbox"/> YES (Please list below) <input type="checkbox"/> NO							
TYPE OF INSURANCE PLAN		NAME AND ADDRESS OF INSURANCE COMPANY				POLICY NUMBER	
TYPE OF INSURANCE PLAN		NAME AND ADDRESS OF INSURANCE COMPANY				POLICY NUMBER	
<b>AUTHORIZATION TO RELEASE INFORMATION:</b> I hereby authorize the release of information related to my employment, medical, dental, physical, mental, alcohol or drug abuse history to K&K Insurance, its employees or agents for the purpose of validating and determining benefits payable under the USA Water Ski Club Insurance Program Participant Accident policy. This authorization or a photo static copy of the original shall be valid for the duration of my claim.					SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)		
<b>AUTHORIZATION TO PAY PROVIDERS:</b> I authorize payment associated with my injury directly to the medical/health care providers.					SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)		
<b>I certify that the foregoing information is true and correct.</b>			SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)			DATE	

**The issuance of this form is not an admission of liability or recognition of the validity of any claim, and is without prejudice to the Company's legal rights.**



# USA WATER SKI CLUB INSURANCE PROGRAM MEDICAL CLAIM FILING PROCEDURES

**NOT FOR USE WITH USA WATER SKI SANCTIONED EVENTS.**

**Notice to Participants in Club approved, sponsored, organized and/or supervised Activities or Events**

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If you are injured while participating in a Club approved, sponsored, organized and/or supervised activity or event, please notify a Club official of your injury so that an Incident Report form can be prepared. If an Incident Report is not prepared to document your injury, your claim will likely be denied by the Club Participant Accident carrier.

Should you require medical treatment as a result of your injury, the on-site Club Official will provide you with a Medical Claim form. The Incident Report form and the Medical Claim form are both available to all Clubs via the USA Water Ski web site: [www.usawaterski.org](http://www.usawaterski.org) (under Insurance Resources/Club Insurance Program).

**Please follow these instructions when submitting your Participant Accident medical claim:**

**DO NOT SUBMIT CLAIM FORMS, MEDICAL BILLS OR OTHER ITEMS TO USA WATER SKI.**

1. Submit your medical expenses to your primary medical/health insurance provider for consideration and payment. Your primary coverage would include group medical/health insurance available through your employer, spouse, parent or legal guardian, Medicare, Medicaid, Armed Forces or other coverage. The Club Participant Accident coverage is secondary (i.e. excess) to your primary coverage.
2. Your primary medical/health insurance carrier will issue an Explanation of Benefits (EOB) showing payment or denial of each medical expense related to your injury.
3. Once you receive the EOB paperwork from your primary medical/health insurance carrier, please complete the Club Participant Accident Medical claim form. Be sure to attach the following documents to your completed Club Participant Accident Medical claim form:
  - The Itemized Insurance Billing form(s) from your physician (HCFA form), hospital (UB 92) or other provider. These forms must show the following: Patient's Name, Condition/Diagnosis, Type of Treatment, Date Expense Incurred and the Charges.
  - The Explanation of Benefits (EOB) form(s) showing payment or denial of each medical billing.
4. Submit your completed Club Participant Accident Medical Claim form along with the Itemized Insurance Billing forms and your Explanation of Benefits form(s) to:

***By mail:***

K&K Insurance Group, Inc.  
ATTN: Claims Department  
1712 Magnavox Way, P.O. Box 2338  
Ft. Wayne, IN 46804

***By facsimile:***

312-381-9077

***By email:***

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