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.

TO BE COMPLETED BY INJURED PARTY (OR BY PARENT/LEGAL GUARDIAN IN CASE OF A MINOR)

NAME (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	MINOR: ☐ YES ☐ NO MARRIED: ☐ YES ☐ NO	☐ MALE ☐ 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: ☐ ACTIVE MEMBER ☐ GUEST/BASIC SKILLS MEMBER MEMBERSHIP #:____________________

SPORT DISCIPLINE:
☐ AWSA (3 Event): ☐ AKA (Kneeboard) ☐ NCWSA (Collegiate) ☐ NWSRA (Ski Racing) ☐ WSDA (Disabled)
☐ ABC (Barefoot) ☐ USW (Wakeboard) ☐ NSSA (Show Ski) ☐ USHA (Hydrofoil)

TYPE OF CLUB ACTIVITY OR EVENT:
☐ TOURNAMENT ☐ PRACTICE ☐ EXHIBITION ☐ OFFICIALS CLINIC ☐ BASIC SKILLS CLINIC
☐ OTHER: ____________________

DID THE INJURY OCCUR DURING A CLUB ORGANIZED EVENT?: ☐ YES ☐ NO
DID THE INJURY OCCUR WHILE TRAVELING TO/FROM THE EVENT? ☐ YES ☐ NO

NAME OF EVENT:	NAME OF SAFETY/CLUB OFFICIAL OR EVENT ORGANIZER:	TEL. # ( )
NATURE OF INJURY:	DATE OF INJURY:	TIME OF INJURY: __________ ☐ AM ☐ PM

FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:

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? ☐ YES (Please list below) ☐ NO

TYPE OF INSURANCE PLAN	NAME AND ADDRESS OF INSURANCE COMPANY	POLICY NUMBER
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AUTHORIZATION TO RELEASE INFORMATION: 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)
AUTHORIZATION TO PAY PROVIDERS: I authorize payment associated with my injury directly to the medical/health care providers.	SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)

I certify that the foregoing information is true and correct.	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.

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Important Claim Notice

Notice to Alaska Claimants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Claimants: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas, Delaware, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, and West Virginia Claimants: Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material, thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and [NY: Substantial] civil penalties. In LA, ME, TN, and VA, insurance benefits may also be denied.

Notice to California Claimants: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties many include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Claimants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Claimants: Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or ting material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or
S 775.084, Florida Statutes.

Notice to Hawaii Claimants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

Notice to Indiana Claimants: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Notice to Maryland Claimants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to Nevada Claimants: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Notice to Ohio Claimants: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Rhode Island Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Washington Claimants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

____ ________________________

SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR) **Date**

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 (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:
   KK_PAClaims@kandkinsurance.com