OKLAHOMA YOUTH SOCCER
CLAIM FORM

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT, OR GUARDIAN (REQUIRED)

1. Name of Claimant:____________________
2. Address:____________________
   City:__________ State:__________ Zip:__________
3. Phone: ( ) __________ Email:__________
4. Date of Birth:__________ ❑ Male ❑ Female Social Security #__________
5. Claimant is a: ❑ Player ❑ Coach ❑ Official ❑ Other:__________
6. Accident Date:__________ Accident Time:__________ ❑ AM ❑ PM
7. Body part injured:____________________
8. Accident occurred during: ❑ Game ❑ Practice ❑ Tournament ❑ Camp/Clinic
9. Describe how and where accident occurred:____________________
10. Name of field/facility where accident occurred:____________________

SECTION II (REQUIRED)

1. Name of Team/Club/League:____________________
2. Type: ❑ Competitive ❑ Recreational ❑ Official
3. Location: ❑ On Field ❑ Indoor ❑ Spectator Area
4. Surface: ❑ Dirt ❑ Grass ❑ Outdoor Turf ❑ Indoor Turf
5. Surface Condition: ❑ Dry/Normal ❑ Wet/Rainy ❑ Icy ❑ Muddy
5. Position:____________________
6. Status: ❑ Hit by Object ❑ Collision with Opponent ❑ Collision with Teamate ❑ Other:__________

SECTION III TO BE COMPLETED BY OKLAHOMA YOUTH SOCCER (REQUIRED)

1. Policy Number: BAX-308642-00 Policy Effective Date: 9/1/19 Policy Expiration Date: 9/1/20
2. Name of Policy Holder: Oklahoma Soccer Association Phone: (918) 627-2663
3. Address: P.O. Box 35174
   City: Tulsa State: Oklahoma Zip: 74153
4. Verify that accident occurred during an activity sponsored or sanctioned by your organization, and whether claimant was a member at the time of the accident: ❑ YES, Sponsored/Sanctioned activity
   ❑ YES, Claimant was active member on date of accident
5. I certify that the forgoing information is true and correct.
   Authorized Signature:__________ Title:__________ Date:__________

SECTION IV — STATEMENT OF OTHER INSURANCE (REQUIRED)

RELATIONSHIP TO CLAIMANT: ❑ SELF ❑ FATHER ❑ MOTHER ❑ SPOUSE ❑ GUARDIAN

INJURED PERSON:____________________

EMPLOYER NAME:____________________

EMPLOYER ADDRESS:____________________

CITY:____________ STATE:______ ZIP:______

EMPLOYER PHONE: (   )____________________

GROUP INSURANCE COMPANY:____________________

POLICY NUMBER:____________________

INSURANCE COMPANY ADDRESS:____________________

CITY:____________ STATE:______ ZIP:______

SOCIAL SECURITY NUMBER:____________________

SIGNATURE:____________________

RELATIONSHIP TO CLAIMANT: ❑ SELF ❑ FATHER ❑ MOTHER ❑ SPOUSE ❑ GUARDIAN

INJURED PERSON:____________________

EMPLOYER NAME:____________________

EMPLOYER ADDRESS:____________________

CITY:____________ STATE:______ ZIP:______

EMPLOYER PHONE: (   )____________________

GROUP INSURANCE COMPANY:____________________

POLICY NUMBER:____________________

INSURANCE COMPANY ADDRESS:____________________

CITY:____________ STATE:______ ZIP:______

SOCIAL SECURITY NUMBER:____________________

SIGNATURE:____________________

(If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead)

1. Is claimant covered under any other medical and/or dental insurance policy? ❑ Yes ❑ No
2. Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ❑ Yes ❑ No
3. Is claimant enrolled in any federal or state sponsored healthcare plans made available through the Affordable Care Act that is not government subsidized? ❑ Yes ❑ No
4. Is claimant registered with any other soccer organization (such as US Club Soccer, AYSO, etc)? ❑ Yes ❑ No
   If yes, name of organization:____________________

NOTE: If the injured has medical coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address, and phone number of the responsible party.

Name:____________________ Phone: (   )____________

Address:____________________

City:____________ State:____________ Zip:____________

SECTION V — ASSIGNMENT OF BENEFITS

All claims benefits will be paid directly to doctors and hospitals involved, unless billing provided indicates payment made by you.

SECTION VI — STATEMENT OF CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION (REQUIRED)

1. I CERTIFY THAT THE ABOVE INFORMATION GIVEN BY ME IN SUPPORT OF THIS CLAIM IS TRUE AND CORRECT.

____________________ ____________

SIGNATURE OF PARENT/GUARDIAN/CLAIMANT (REQUIRED) DATE

2. I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL OR OTHER MEDICALLY RELATED FACILITY, INSURANCE COMPANY, OR OTHER ORGANIZATION, INSTITUTION OR PERSON THAT HAS ANY RECORDS OR KNOWLEDGE OF ME, AND/OR THE ABOVE NAMED CLAIMANT, TO DISCLOSE, WHENEVER REQUESTED TO DO SO BY K&K INSURANCE/SPECIALTY BENEFITS OR NATIONWIDE LIFE INSURANCE COMPANY, ANY AND ALL SUCH INFORMATION. I UNDERSTAND THE INFORMATION OBTAINED BY USE OF THE AUTHORIZATION WILL BE USED TO DETERMINE ELIGIBILITY FOR INSURANCE AND ELIGIBILITY FOR BENEFITS UNDER ANY EXISTING POLICY. ANY INFORMATION OBTAINED WILL NOT BE RELEASED TO ANY PERSON OR ORGANIZATION EXCEPT AS NECESSARY IN CONNECTION WITH THE PROCESSING OF THIS APPLICATION, CLAIM, OR AS MAY BE OTHERWISE LAWFULLY REQUIRED OR AS I MAY FURTHER AUTHORIZE. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNED:____________________ DATE:____________

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

HOW TO FILE A CLAIM
INSTRUCTIONS

All important information must be provided in order for claims to be processed.

1. **Excess Coverage:** Accident medical expenses are covered under this policy on an Excess Basis, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. If you receive Government or State Aid Insurance, (Medicaid, Medicare, etc) this insurance may be Primary.
   - Payment under this policy will be made according to usual and customary guidelines. This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have up to 15 months from the date of injury to submit claim form. For claims to be eligible for coverage you must seek medical attention within 90 days from date of injury.

3. **Please Remember:**
   - After your claim is validated by your state soccer association *(see section III of claim form)* it will be forwarded to K&K Insurance/Specialty Benefits, who will send you a coverage letter and your claim number. Advise your Doctors/Hospitals so they can file claims directly to your primary insurance first, and K&K Insurance/Specialty Benefits second.
   - Itemized bills are required: You or your providers must submit itemized bills with your primary insurance explanation of benefits (if applicable); balance due bills or notices do not provide the information needed to process your claim. See below for forms needed. Payments will be made to you if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.
     1. **CMS-1500** is the standard form used by Providers to show the medical treatments and charges made for each service.
     2. **UB-04** is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental Bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy. Please have your provider submit an ADA dental claim form with the explanation of benefits (if applicable).

For further information contact:

K&K Insurance Group, Inc.
Claims Department
PO Box 2338
Fort Wayne, Indiana 46801-2338

Phone: (800) 237.2917 option 1
Fax: (312) 381.9077
Email: KK.PAClaims@kandkinsurance.com

APPLICABLE IN ALABAMA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

APPLICABLE IN ALASKA
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.

APPLICABLE IN ARIZONA
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.

APPLICABLE IN ARKANSAS, DELAWARE, KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, VIRGINIA, AND WEST VIRGINIA
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.

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

APPLICABLE IN COLORADO
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 may 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

APPLICABLE IN THE DISTRICT OF COLUMBIA
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.

APPLICABLE IN FLORIDA
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 thing 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.

APPLICABLE IN HAWAII
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.

APPLICABLE IN IDAHO
Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN INDIANA
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.

APPLICABLE IN KANSAS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

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

APPLICABLE IN MINNESOTA
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEVADA
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.

APPLICABLE IN NEW HAMPSHIRE
Any person who, with 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.

APPLICABLE IN OHIO
Any person who, with intent to defraud or knowing that he/she 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.

APPLICABLE IN OKLAHOMA
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.

APPLICABLE IN WASHINGTON
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.

FRAUD CLAIMS (2013/01)

Dear Participant: If you have an appointment with a doctor as the result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates:

The First Health. Network

HYGEIA