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

Wyoming High School Activities Association
Concussion Coverage

(PLEASE PRINT)

NATURE
❑ BODILY INJURY ❑ OTHER:_____

TIME & PLACE OF INCIDENT
DATE:_____ TIME:_____ ❑ AM ❑ PM
EVENT NAME:_____
EVENT TYPE:_____ CONDUCTED BY:_____
LOCATION:_____

HAPPENED TO
NAME:_____ SSN:_____
DATE OF BIRTH: _____ SEX: ❑ Male ❑ Female PHONE: (_____)_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

FUNCTION
AS: ❑ ATHLETE
❑ OTHER:_____

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION:_____
❑ 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:_____

OTHER SCHOOL INSURANCE
DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? ❑ Yes ❑ No
IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY:_____

INSURED
NAME OF INSURED:_____ POLICY#:_____
WHSAA MEMBER SCHOOL NAME:_____ PHONE: (_____)_____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
❑ WHSAA Member School Administrator ❑ 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 OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: ❍ Yes ❍ No

NAME OF INSURED:_____ POLICY NO: _____

FATHER

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: _____

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.

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) _____

MOTHER

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.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

POLICY NUMBER:_____

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- ❍ 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:_____ PARENT/GUARDIAN/MOTHER SIGNATURE:_____

DATE:_____ DATE:_____