

## SCOTT COUNTY BOARD OF EDUCATION

**Effective July 1, 2021 through June 30, 2022**

To Parents/Guardian:

The Scott County Board of Education will provide accident insurance for the 2021-2022 school year for all students. Please note that the insurance is "secondary" to any other insurance coverage the family may have and will pay only on eligible medical expenses not payable by other sources of coverage.

### Benefits

The policy pays 100% of reasonable, customary and Medically Necessary covered expenses which result from an accident which occurs while participating in a school-sponsored, school-supervised activity. The policy includes a \$1,000 Physical Therapy benefit. The Basic policy provides benefits for both students and athletes, up to the policy maximum of \$25,000 for two years from the date of injury. For students and middle school athletes and below, the Catastrophic coverage provides benefits from \$25,000 up to \$5,000,000, and for high school athletes, the Catastrophic coverage is provided by the Kentucky High School Athletic Association. This is a brief summary of benefits, and all claims are paid per the policy provisions.

### How To File A Claim

To Process your claim, please submit the following three pieces of information:

1. Completed and Signed Claim Form
2. Itemized Bills
3. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed, faxed or emailed to:

#### **K & K Insurance**

#### **Claims Department**

1712 Magnavox Way / P. O. Box 23381

Fort Wayne, IN 46801-2338

[kk.PAclaims@kandkinsurance.com](mailto:kk.PAclaims@kandkinsurance.com) – email

**800-237-2917**

**312-381-9077 – Fax**

1. The Claim Form enables K & K Insurance to open a claim for the treatment of your injury. To avoid delays in claim processing, please be sure the "other insurance" portion of the claim form is completed in full. The claim form must be signed by a school official such as a principal, coach or athletic trainer.
2. Itemized Bills: Please include copies of all medical bills showing the name and address of the provider of service, date of service, type of service and the charges. Account statements or "Balance Due" statements are helpful, but do not contain all the information needed to process the charges.
3. Explanation of Benefits: If you have other medical insurance, all medical bills must be first submitted to that carrier for their determination of eligibility. If the charges are not paid in full by the other medical insurance carrier, we will need to see a copy of the "Explanation of Benefits" from that carrier, prior to issuing benefits from this office. If you have primary medical insurance, the need for an "Explanation of Benefits" will not be applicable to your claim.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR CLAIM, PLEASE CALL:

K & K  
**1-800-237-2917**

-or-

Bobbi Land at [bobbi@bobrobertsins.com](mailto:bobbi@bobrobertsins.com)  
Roberts Insurance  
**859-623-7684 or 1-877-757-2581**

## TIPS FOR EFFICIENT STUDENT ACCIDENT CLAIM PROCESSING

1. The Claim Form must be completed in its entirety and signed by both parents and a school official.
2. The date of the accident and a detailed description are required to verify that the incident was school-related.
3. The claim form should be submitted to K & K Insurance within 60 days of the accident. **THE BASIC COVERAGE HAS A BENEFIT PERIOD OF TWO YEARS FROM THE DATE OF THE ACCIDENT. TREATMENT MUST OCCUR WITHIN 60 DAYS OF THE ACCIDENT.**
4. In addition to the claim form, the company will also require the following, in Order to make payment.
  - Itemized physician, hospital or other provider bill that includes the diagnostic and procedure codes  
**NOTE:** For hospital charges, a **Form UB04** is required. For physical/ancillary charges, a **Form CMS1500** is required.
  - Explanation of Benefits from primary carrier

For questions regarding claims:

**Roberts Insurance & Investments**

Bobbi Land [bobbi@bobrobertsins.com](mailto:bobbi@bobrobertsins.com) or  
Stephanie Branham [stephanie@bobrobertsins.com](mailto:stephanie@bobrobertsins.com)  
**859-623-7684 or 1-877-757-2581**



**SPECIALTY  
BENEFITS, INC.**  
an affiliate of K&K Insurance Group, Inc.



**STUDENT OR ATHLETE  
ACCIDENT CLAIM FORM**  
**Excess Coverage  
K-12 ACCOUNTS**

**CLAIMS DEPARTMENT**  
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338  
Ph: 800-237-2917 | Fax: 312-381-9077 California License #0334819  
email: kk.PAclaims@kandkinsurance.com  
www.kandkinsurance.com

**INSTRUCTIONS FOR FILING**

**NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.**

**Basic Procedures for Submitting Statement of Claim**

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

**To the Student or Athlete/Parent/Guardian**

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

**SECTION I - TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)**

1. Student's Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ Sex:  Male  Female

3. Student's grade in school: \_\_\_\_\_

4. Home Address Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent(s)/Guardian(s) Home Phone: \_\_\_\_\_

5. Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  AM  PM  
Nature of Injury: \_\_\_\_\_ Describe exactly how accident happened: \_\_\_\_\_

6. Nature of activity and location during which the injury occurred (check all boxes which apply):

<input type="checkbox"/> Pre-Kindergarten	<input type="checkbox"/> Elementary School	<input type="checkbox"/> Middle School
<input type="checkbox"/> High School	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Classroom Activities
<input type="checkbox"/> Interscholastic Sports	<input type="checkbox"/> Intramural Sports, <i>name of sport, if applicable:</i> _____	
<input type="checkbox"/> Club Sports	<input type="checkbox"/> Physical Education Class	<input type="checkbox"/> Other Activity (specify) _____
<input type="checkbox"/> During Practice	<input type="checkbox"/> During Play	<input type="checkbox"/> During Travel To or From the Event

Nature of Your Participation:

<input type="checkbox"/> Student	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Student/Manager
<input type="checkbox"/> Athletic Participant	<input type="checkbox"/> Cheerleader	<input type="checkbox"/> Band Member
<input type="checkbox"/> Other (specify) _____		

7. Transfer Student?  Yes  No  
If yes, please identify the former school name: \_\_\_\_\_

8. Name, address and phone number of physician who first treated you: \_\_\_\_\_

9. Have you had a similar injury in the past?  Yes  No

If yes, describe and give dates: \_\_\_\_\_

10. Name, address and phone number of physician who treated you for previous injury: \_\_\_\_\_

11. Are you covered by any other medical expense benefits plan?  Yes  No

If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

**IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.**

**ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.**

**THIS IS EXCESS MEDICAL COVERAGE.**

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits and/or The Hartford or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms for insurance 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.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

**SECTION II - (TO BE COMPLETED BY PARTICIPATING SCHOOL)**

**FAILURE TO COMPLETE THIS FORM IN FULL  
MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.**

1. Students Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

2. Date of Accident \_\_\_\_\_

3. Activity \_\_\_\_\_

4. Nature of Injury \_\_\_\_\_

5. Name of participating SCHOOL SYSTEM or SCHOOL DISTRICT \_\_\_\_\_

6. Name of participating SCHOOL \_\_\_\_\_

7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNATURE OF SCHOOL OFFICIAL: \_\_\_\_\_

PRINTED NAME/TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_ DATE: \_\_\_\_\_

Any person who knowingly and with intent to defraud any insurance company or other person files claim forms for insurance 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.

Date \_\_\_\_\_ Policyholder (School Official) Signature \_\_\_\_\_

**For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington:** 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.

**For Residents of 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.

**For Residents of California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

**For residents of 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

**For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines and denial of insurance benefits.

**For residents of 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.

**For residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

**For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**For residents of Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.