Effective July 1, 2018 through June 30, 2019

SCOTT COUNTY BOARD OF EDUCATION

TO: Parent/Guardian:

The Scott County Board of Education will provide accident insurance for the 2018-2019 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 $1000 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 – 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" statement 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
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 or
Stephanie Branham stephanie@bobrobertsins.com
859-623-7684 or 1-877-757-2581

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

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

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

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):

☐ Pre-Kindergarten	☐ Elementary School	☐ Middle School
☐ High School	☐ Cafeteria	☐ Classroom Activities
☐ Interscholastic Sports	☐ Intramural Sports, *name of sport, if applicable:* _____	
☐ Club Sports	☐ Physical Education Class	☐ Other Activity (specify) _____
☐ During Practice	☐ During Play	☐ During Travel To or From the Event

   Nature of Your Participation:

☐ Student	☐ Volunteer	☐ Student/Manager
☐ Athletic Participant	☐ Cheerleader	☐ Band Member

   ☐ 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 Zurich Insurance 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 _____

K&K INSURANCE

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)_____

DATE OF BIRTH:_____

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)_____

DATE OF BIRTH:_____

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)_____

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:_____

DATE:_____

PARENT/GUARDIAN/MOTHER SIGNATURE:_____

DATE:_____