CLAIM FILING PROCEDURES (for office use only)

State Association Code:_____
Current League Code:_____
Current Team Code:_____

CLAIM PROCEDURE:

1. Participant (or legal guardian if under the age of 18) must complete this form in its entirety or it may be returned to you by the U.S.A.S.A. State Association.
2. **Do not delay submitting this claim form!** This form must be received, with or without attachments, within 90 days from the date of the accident, or benefits may be denied due to untimely filing.
3. Once the claim form is completed, attach any itemized bills with corresponding primary carrier explanation of benefits you have received to date. The completed form must then be sent to your U.S.A.S.A. State Association office for validating.
4. Once the U.S.A.S.A. State Association has validated your claim, they will forward it to the insurance company for processing. The insurance company will inform you of any additional information they may need to process your claim.

1. COMPLETE THIS FORM.
2. ATTACH ALL BILLS
3. MAIL TO:

Michelle Baldwin
c/o Frisoli & Frisoli
797 Cambridge Street
Cambridge, MA 02141

U.S.A.S.A.

Special Risk
ACCIDENT CLAIM FORM
PLEASE PRINT OR TYPE

IF PARTS A and B ARE NOT COMPLETED IN FULL, THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

PART A - This Part MUST be completed, dated and signed by the Injured Person - or by his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.

1. Name of Injured Person (Insured): *(First, Middle, Last)*	1a. Date of Accident: Mo / Day / Year
2. Complete Mailing Address: *(Street)* *(City)* *(State)* *(Zip)*	
3. Area Code/Home Telephone #:	3a. Area Code/Work Phone #:
4. Social Security #:	5. Date of Birth: Mo / Day / Year
6. Male ☐ Female ☐	6a. Single ☐ Married ☐ Full-time Student ☐

7. Are you currently enrolled in any health insurance plan: ☐ Yes ☐ No
   If yes, all bills must be submitted to them first for consideration. If no, see line 7a and 7b.
   7a. If you are not enrolled in any health insurance plan, we require written verification from: your employer and your spouse's employer (if applicable), or Bursar's office if a full-time college student.
   7b. Have you ever been treated for this or a similar condition before? ☐ Yes ☐ No
   If yes, last date treated:_____
   7c. If you are self employed or unemployed and not covered under any health insurance plan, please sign below.

   x_____

PART B - This Part MUST be completed, then signed by an official of your local organization.

1. Team Name:
2. League Name
3. Injury Occurred at: ☐ Event ☐ Practice ☐ Travel
   3a. Name of Event:
   3b. Injury occurred on: ☐ Indoor Field ☐ Outdoor Field
4. Describe how accident occurred:
5. Type of Injury:
6. Name & Phone # of coach, manager or referee present at the time of the accident:

AUTHORIZATION

I waive any provision of law to the contrary and hereby authorize K&K Insurance Group, Inc. or its representatives to furnish to any hospital, physician or other person who has attended me, and my insurance carrier, any and all information with respect to the accidental injury for which I am claiming insurance benefits.

I waive any provision of law to the contrary and hereby authorize any hospital, physician or other person who has attended me, and my insurance carrier or employer, to furnish to K&K Insurance Group, Inc. or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription, or treatments, and copies of all hospital, medical or insurance records including, but not limited to, information regarding other insurance coverages. I agree that a photocopy of this authorization shall be considered as effective as the original.

(The above paragraphs are being used in order to facilitate our obtaining and providing proper information needed to quickly process your claim.)

Signed _____ Date _____