Catholic Mutual
PARTICIPANT ACCIDENT INSURANCE CLAIM FORM

(NOTE To the Participant/Parent/Guardian: Report and Claim Form will be returned if not fully completed and signed.)

Basic Procedures for Submitting the Incident Report and Participant Accident Insurance Claim Form

1. The Parish/School Administrator or Pastor will complete the incident report, sign and date where indicated.

2. The participant or participant's parents/guardian will complete the Accident Medical/Insurance Claim form.

3. Forward the completed Incident Report and Accident Medical/Insurance Claim forms to K&K Insurance Group. BOTH reports should be submitted to K&K at the same time.

PLEASE NOTE: Processing may be delayed if the Report and Accident Medical/Insurance Claim forms are not fully completed, signed and sent together.

To the Participant/Parent/Guardian:

Attach current itemized physician, hospital, or other provider's bills for accident medical expenses being claimed as well as the primary carrier's Explanation of Benefits showing their payments and denials. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made.

MAIL TO:

K&K INSURANCE GROUP, INC.

Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917

For general claims questions or status of a claim call:
800-237-2917, option 1. or efax: 312-381-9077

Department email: KK_PAClaims@kandkinsurance.com *(to be used when forwarding new claims and attachments for existing claims)*

K&K INSURANCE
On behalf of Nationwide Insurance

1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
(800) 237-2917 Fax (260) 459-5915
email: KK_PAClaims@kandkinsurance.com
http://www.kandkinsurance.com

Catholic Mutual
ACCIDENT MEDICAL INSURANCE CLAIM FORM

Insured Name: DIOCESE OF WHEELING-CHARLESTON

Policy Number: FPX0000003881200

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED. OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

MEDICAL BENEFITS UNDER THIS POLICY MAY PROVIDE PRIMARY, EXCESS OR A COMBINATION OF BOTH COVERAGES. UPON RECEIPT OF THIS CLAIM FORM , AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

IF THE MEDICAL BENEFIT IS EXCESS, YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON:_____

FATHER'S NAME (if injured is a minor)_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)

GROUP INSURANCE COMPANY:_____

POLICY NUMBER:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY NUMBER:_____

SIGNATURE:_____

SPOUSE'S NAME (if applicable):_____

MOTHER'S NAME (if injured is a minor)_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)

GROUP INSURANCE COMPANY:_____

POLICY NUMBER:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY NUMBER:_____

SIGNATURE:_____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K 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 OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, 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.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED:_____ DATE:_____

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

K&K INSURANCE
On behalf of Nationwide Insurance

1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
ph (800) 237-2917
Fax (260) 459-5915 for Participant Accident Unit
http://www.kandkinsurance.com

Catholic Mutual INCIDENT REPORT

(PLEASE PRINT)

INSURED
NAME OF INSURED: DIOCESE OF WHEELING-CHARLESTON POLICY#: FPX0000003881200
PARISH/SCHOOL: _____ CITY/STATE: _____

TIME & PLACE OF INCIDENT
DATE: _____ TIME: _____ ❑ AM ❑ PM
ACTIVITY: _____
EVENT TYPE: _____
LOCATION: _____

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

FUNCTION
AS: ❑ PARTICIPANT ❑ VOLUNTEER ❑ STUDENT
❑ OTHER: _____

APPARENT INJURY OR DAMAGE
BODY PART: _____
CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____
❑ 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: _____

WITNESSES (If known)
NAME: _____ NAME: _____
ADDRESS: _____ ADDRESS: _____
PHONE: (____) _____ PHONE: (____) _____

PASTOR/PARISH/ SCHOOL ADMINISTRATOR
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