American Youth Football & American Youth Cheer

PART 2 - Excess Medical Insurance Claim Form

TO BE COMPLETED BY INJURED PERSON OR PARENT

Coverage under this policy is excess over all other valid and collectible health and accident plans. Your claim should be submitted to the insurance company providing coverage to you through your own, your parents' or your spouse's 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. If there is no other valid and collectible insurance, this policy will act as primary insurance. Further details of coverage will be communicated upon receipt of this fully completed claim form.

IMPORTANT NOTES:

- **If Injured Person is a Minor, we must have BOTH parents' information.**
- **If the Injured Person is married, we must have the spouse's information or mark area N/A**
- **ALL information requested on this claim form must be provided. Omission of vital information will cause delay in claim processing.**
- **We will not process your claim without employer information. The data required is imperative & will expedite your claim processing.**

Injured/
Insured Person's Name: _____ Sex: _____ Date of Birth: ____/____/____

Social
Security #: _____ Phone: _____ Spouse's Name (if applicable): _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Fathers Name (if minor): _____ Mothers Name (if minor): _____

Fathers Email Address: _____ Mothers Email Address: _____

Fathers Social Security # :_____ Mothers Social Security #:_____

Employers Name: _____ Employers Name: _____

Employers Address: _____ Employers Address: _____

City: _____ ST: _____ Zip: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Policy #: _____ Phone: _____ Policy #: _____

Group Insurance Company: _____ Group Insurance Company: _____

Insurance Company's Address: _____ Insurance Company's Address: _____

City: _____ ST: _____ Zip: _____ City: _____ ST: _____ Zip: _____

I certify that this injury occurred to an American Youth Football/American Youth Cheer registered member during an American Youth Football/American Youth Cheer sanctioned activity (i.e. supervised game/practice), the above information is true and accurate to the best of my knowledge and belief, and I understand fraudulent statements can be a crime.

Signature: _____ Date: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K INSURANCE GROUP, INC., SPECIALTY BENEFITS, INC. OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY PRIMARY 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, PHYSICAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY PRIMARY 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 PROPER INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

Signature: _____ Date: _____

PLEASE NOTE: If Injured Person is a Minor, signature must be of Parent or Legal Guardian.

PLEASE RETURN THIS FORM TO K&K INSURANCE GROUP PER COVER PAGE INSTRUCTIONS