Concussion Insurance Program Guide

Headstrong Concussion Insurance Policy Information

Minnesota State High School League

Broker: Dissinger Reed
Third Party Administrator (TPA): K&K Insurance
Insurance Carrier: Nationwide Life Insurance Company – AM Best-Rated A+XV

- **Policy #:** JXS0000028405500
- **Coverage Period:** August 1, 2017 – August 1, 2018
- **Deductible:** $0 per claim
- **Eligible Person:** All students, grades 7-12, participating in a Covered Activity at the Varsity, Junior Varsity, B-Squad and Sophomore level.
- **Covered Activities:** Participating in activities, practice or play of sports governed and/or sponsored by the MSHSL
- $25,000 per injury medical maximum
- 1-year benefit period (Benefits will be payable for 1 year from the injury date)
- Usual and Customary 100%
- Accidental Death & Dismemberment $5,000
- Accidental Death and Dismemberment Aggregate $250,000

The HeadStrong Concussion Insurance Program was specifically developed to insure student athletes from the high cost of concussion treatment and neurological follow up.

The student athlete has 'first dollar' coverage (zero deductible) for concussion assessment and treatment.

Coverage is secondary/excess to any other valid and collectable insurance but will become the primary payor, if no other insurance is available.

Program Highlights Include:
- $0 deductible and no Co-pays
- Tele-med Services, when needed
- No restrictions on specific doctors
- No referrals needed for treatment
- No internal limits
- No specific procedure maximums
- Neurological follow up care When medically necessary and billed at U&C.

Contact for Claims:

kk.newpaclaims@kandkinsurance.com
Fax: (260) 459-5915
Phone: (800) 237-2917

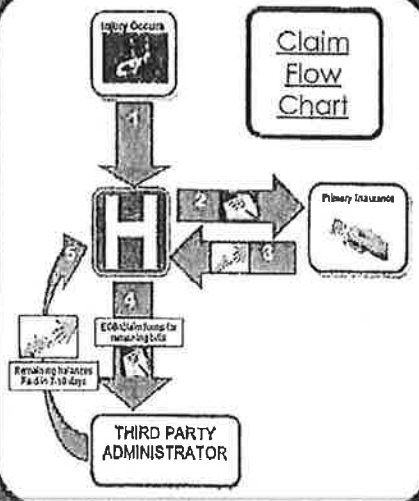
K&K Insurance/Specialty Benefits
1712 Magnavox Way
Ft. Wayne, IN 46804

Please submit the completed and signed claim form along with itemized bills and EOB's from the primary insurance carrier. The more information you can provide upfront, the better. Claims payments are expedited with CLEAN submissions allowing us to pay you providers quickly.

Third Party Administrator

K&K Insurance

www.kandkinsurance.com



HOW TO SUBMIT A CLAIM UNDER THE CONCUSSION PROGRAM

1) Submit the incident report within 365 days of the injury.
2) Make certain that the incident report is completed in its entirety, including the policy number (JXS0000028405500), with accurate and detailed injury information and how the accident happened.
3) The incident report MUST BE SIGNED by a representative of the school. INCIDENT REPORTS WHICH ARE NOT SIGNED, WILL DELAY THE CLAIM.
4) Physician billings on CMS1500 forms and hospital/facility billings on UB04 forms would be preferred as these forms contain all the necessary coding required to process a claim. See bullets #5 & 6 for additional instruction regarding bills.
5) If the injured participant has primary insurance, each bill should be submitted with the primary insurance Explanation of Benefits or denial.
6) If the injured participant has primary insurance, all providers should be informed of the primary insurance information so they are billed first, and the K&K information for the concussion program insurance billed second.
7) When the injured participant does not have primary insurance, we have agreements through PPO networks that allow many bills to be reduced with contractual discounts. We encourage injured participants NOT to pay claims in advance of submitting them to us, so these discounts can be used.

PRIMARY CONTACT

James Maxwell
1660 School St.
Ste 101A
Moraga, CA 94556
Phone:(415) 517-4545
jmaxwell@dissingerreed.com

HeadStrong

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
http://www.kandkinsurance.com

K&K INCIDENT REPORT

Minnesota State High School League
Concussion Coverage

(PLEASE PRINT)

NATURE
❑ BODILY INJURY ❑ OTHER:_____

TIME & PLACE OF INCIDENT
DATE:_____ TIME:_____ ❑ AM ❑ PM
EVENT NAME:_____
EVENT TYPE:_____ CONDUCTED BY:_____
LOCATION:_____

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

FUNCTION
AS: ❑ ATHLETE
❑ OTHER:_____

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION:_____
❑ 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:_____

OTHER SCHOOL INSURANCE
DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? ❑ Yes ❑ No
IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY:_____

INSURED
NAME OF INSURED: Minnesota State High School League POLICY#: JXS0000028405500
CLUB NAME:_____ PHONE:(___)_____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
❑ MSHSL Member School Administrator ❑ OTHER:_____
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

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
(800) 237-2917 Fax (312) 381-9077
email: KK.PAClaims@kandkinsurance.com
http://www.kandkinsurance.com

PARTICIPANT ACCIDENT OTHER INSURANCE FORM

Insured Name:_____

Policy Number:_____

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_____

DATE OF BIRTH_____

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:_____

DATE OF BIRTH_____

SIGNATURE:_____

QUESTIONS REGARDING INCOME ARE ONLY APPLICABLE IF POLICY AFFORDS WEEKLY INDEMNITY BENEFITS.

REGULAR WEEKLY INCOME:_____

ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME WORK?_____

INCOME LOST PER WEEK DUE TO INJURY:_____

ON WHAT DATE DID YOU, OR DO YOU EXPECT TO, RESUME RACING AND/OR PARTICIPATE IN A RACING EVENT?_____

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

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:_____