



# United States Judo Federation Accident Claim Form

Our insurance plan has been designed to provide benefits at a minimal cost for USJF members. This insurance is excess over other insurance you may have and benefits will only be paid for those eligible expenses left unpaid by other insurance.

1. Please type or print clearly. The claim form must be properly completed. "None" or "Not Applicable" should be used when appropriate. The form must be signed by: the injured member, their parent or guardian (if member is a minor), and the club coach. Incomplete or improperly completed forms cannot be processed and will be returned.
2. This form must be completed and mailed to the USJF National Office **within 60 days** of the date of the injury to report the accident. **Failure to do so will void your coverage.**
3. File all bills with your primary family health and accident carrier first. This may include employee plans, military plans, welfare plans, service contracts, and etc. After you have received a notice of payment, notice of denial, or letter stating you have met your deductible from your primary carrier, forward that statement to the USJF National Office.

USJF National Office • P.O. Box 338 • Ontario, OR 97914-0338 • Phone (541) 889-8753 • FAX (541) 889-5836 • FAX2 (413) 502-4983

## PART A MEMBER INFORMATION

1. Name of Injured Member (Last, First, MI)		2. Birth Date	3. Sex
4. Address			
5. Telephone Home _____ Work _____		6. Email	
7. Membership No. USJF # <input type="checkbox"/> USJI # <input type="checkbox"/> USJA # <input type="checkbox"/>		8. Name of Judo Club	
9. Name & Address of Employer			

## PART B PARENT/LEGAL GUARDIAN STATEMENT

1. Name of Living Parent(s) or Legal Guardian(s)		2. Relationship <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian	
3. Address of Parent or Legal Guardian			
4. Telephone of Parent or Legal Guardian Home _____ Work _____		5. Email	
6. Name & Address of Father's/Legal Guardian's Employer			
7. Name & Address of Mother's/Legal Guardian's Employer			

## PART C ACCIDENT INFORMATION

1. Injury Occurred At (Name of Place or Event)		2. Date Of Injury	3. Injury Occurred During <input type="checkbox"/> Practice <input type="checkbox"/> Tournament <input type="checkbox"/> Travel <input type="checkbox"/> Camp/Clinic <input type="checkbox"/> Other	
4. Details On How Injury Occurred		5. What Part Of Body Was Injured		
6. At the time of the accident, was the injured person involved in any activity under the jurisdiction of a USJF coach, trainer, or sanctioned event official? <input type="checkbox"/> YES <input type="checkbox"/> NO		7. Name of Coach or Official Were they a witness to the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO		8. Has a previous claim been filed? <input type="checkbox"/> YES <input type="checkbox"/> NO

## PART D OTHER HEALTH INSURANCE COVERAGE

Give name, address, and policy number of all other Health & Accident Insurance Plans (including those of Parents or Guardians) that may cover this claim.

## PART E CERTIFICATION

<b>CERTIFICATION BY USJF COACH</b> I certify that all of the above is correct to the best of my knowledge. I <input type="checkbox"/> did <input type="checkbox"/> did not witness the accident. _____ Date _____ Signature		<b>CERTIFICATION BY USJF NATIONAL OFFICE</b> I certify that the above claimant was a current member and was covered by USJF insurance at the time of the accident. _____ Date _____ Signature	
--	--	---	--



# MEDICAL CLAIM FORM

# United States Judo Federation

This form to be completed whenever a medical claim results from an injury incurred by a USJF member at an insured and supervised training or sanctioned event.  
(Please check and/or circle one per section, and complete relevant blanks.)



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

1712 Magnavox Way, P.O. Box 2338  
Fort Wayne, Indiana 46801-2338  
Phone: 800-237-2917  
Fax (260) 459-5915

ON BEHALF OF NATIONWIDE INSURANCE

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: (M) (F) Date of Birth: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Dojo/Club Name: \_\_\_\_\_  
 USJF Membership Number: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Injured party was:  Participant  Other: \_\_\_\_\_  
 If Participant, please check membership type:  Annual Member  Other: \_\_\_\_\_  
 Name of Event: \_\_\_\_\_  
 USJF Club Authorized Representative name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 USJF Club Authorized Representative signature: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_  A.M.  P.M.  
 Body Part Injured: \_\_\_\_\_  Left  Right  Both  N/A  
 Disposition:  On-Site Care Only  Ambulance to \_\_\_\_\_ City: \_\_\_\_\_  
 Condition (Laceration, Concussion, Sprain, Fracture, etc.): \_\_\_\_\_  
 Describe activity engaged in at time of accident: \_\_\_\_\_  
 Describe where accident happened: \_\_\_\_\_  
 Describe how accident happened: \_\_\_\_\_  
 Did the accident occur during:  Competition  Practice  Traveling to/from  Other: \_\_\_\_\_  
 Witness Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If injured party is a minor:  
 Parent/Guardian Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Does injured person have other insurance?  Yes  No  
 If yes, name and address of insurance company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health care provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable including disability or employment related information, to K&K Insurance Group, Inc./Specialty Benefits Inc., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorized upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.

Name of Patient: \_\_\_\_\_ Signature of Patient: (Parent/Guardian if a minor) \_\_\_\_\_ Date: \_\_\_\_\_

AUTHORIZATION TO PAY PROVIDER - I authorize payment associated with this incident directly to the physicians or providers.  
IF YES, SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

I certify that the foregoing information is true and correct. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to: UNITED STATES JUDO FEDERATION, P.O. Box 338, Ontario, OR 97914-0338**

# **PLEASE READ INSTRUCTIONS**

1. MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO UNITED STATES JUDO FEDERATION, P. O. Box 338, Ontario, OR 97914-0338
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital or other providers' standard insurance billing forms: HCFA from physician or UB92 from Hospital. These forms must show the following: Patients Name, Condition/Diagnosis, Type of Treatment, Date expense incurred and Charges.
4. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Medicare, Medicaid, Armed Forces or other coverage.
5. To expedite proper processing, submit form completed in full along with the above documents to UNITED STATES JUDO FEDERATION (Initial Report).
6. Subsequent bills, Explanations of Benefits, documents should be sent to K&K Insurance Group, inc. Please include your claim number with your documents.



**K&K Insurance Group, Inc./Specialty Benefits  
Claims Department,  
PO Box 2338, Fort Wayne, IN 46801-2338  
Phone: 1-800-237-2917 • Fax: 1-260-459-5910**



### **Applicable in Arizona**

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

### **Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington and West Virginia**

Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim 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, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied.

### **Applicable in California**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **Applicable in Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

### **Applicable in Florida and Idaho**

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false,

incomplete or misleading information is guilty of a felony.\*

\* In Florida - Third Degree Felony

### **Applicable in Hawaii**

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

### **Applicable in Indiana**

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

### **Applicable in Minnesota**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

### **Applicable in Nevada**

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

### **Applicable in New Hampshire**

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

### **Applicable in Ohio**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

### **Applicable in Oklahoma**

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.