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 # ☐ USJI # ☐ USJA #	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 ☐ Father ☐ Mother ☐ 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 ☐ Practice ☐ Tournament ☐ Travel ☐ Camp/Clinic ☐ 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? ☐ YES ☐ NO	7. Name of Coach or Official Were they a witness to the accident? ☐ YES ☐ NO	8. Has a previous claim been filed? ☐ YES ☐ 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**

CERTIFICATION BY USJF COACH I certify that all of the above is correct to the best of my knowledge. I ☐ did ☐ did not witness the accident. Date _____ Signature _____	CERTIFICATION BY USJF NATIONAL OFFICE I certify that the above claimant was a current member and was covered by USJF insurance at the time of the accident. Date _____ Signature _____

Previous Editions Of This Form Are Obsolete And Should Not Be Used

IF CLAIM IS FOR A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN THIS FORM

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.)

K&K INSURANCE

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

Completion of this form does not guarantee benefits and is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

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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

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

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

PHCS

The First Health Network

HYGEIA

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.