(Check and/or circle one per section, complete relevant blanks.)

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801-2338
800-237-2917 Fax (260) 459-5910

ACCIDENT REPORT

MOTORSPORTS OVAL TRACKS

INJURED: (Driver) (Pit Crew) (Official) (Spectator) (Other:_____)

Name:_____ Age:_____ Sex: (M) (F)

Address:_____

City:_____ State:_____ Zip:_____ Phone:(_____)_____

Years Experience, this Level: (1st) (1-3) (4-9) (10+)

TRACK NAME/LOCATION: (Indoor) (Outdoor)

_____

Policy #:_____

Sanctioned by:_____ Race:_____ Track Length:_____

INJURY:

DATE OF INJURY:_____

INJURED BODY PART:_____

CONDITION:_____

(Sprain, Fracture, Concussion, etc.)

ESTIMATED ABSENCE FROM WORK: (1-7 days) (1-3 weeks) (3+ weeks)

DOES INJURED DRIVER HAVE OTHER INSURANCE? (Y) (N) Company:_____

TIME:

- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ Lights

DISPOSITION:

- ❑ On-Site Care Only
- ❑ Ambulance to:

  _____

  City:_____
- ❑ Fatality

TYPE:

- ❑ STOCK CAR (Modified) (Super Mod) (Street) (Demo)
- ❑ OPEN WHEEL (Midget) (Sprint) (Outlaw) (Modified) (CART) (Indy Car)
- ❑ TRUCK (Pickup) (Semi)
- ❑ GO-KART (Sprint) (Enduro)
- ❑ MOTORCYCLE: (Class_____)
- ❑ VINTAGE
- ❑ OTHER:_____

OCCASION:

- ❑ PRE-RACE
- ❑ PRACTICE
- ❑ TIME-TRIALS
- ❑ HEAT
- ❑ PIT STOP
- ❑ YELLOW FLAG
- ❑ DURING RACE: (Start) (Early) (Mid) (Late) (Finish)
- ❑ BETWEEN RACES
- ❑ AFTER RACES

LOCATION:

- ❑ LOADING AREA (Garage)
- ❑ PITS (Infield) (Outside)
- ❑ PIT ENTRANCE (Infield) (Outside)
- ❑ PIT EXIT (Infield) (Outside)
- ❑ TURN #_____
- ❑ STRAIGHTAWAY
- ❑ FENCE (CC) (Wheel)
- ❑ GRANDSTAND (Seats) (Steps)
- ❑ Row #: (Low) (Mid) (Upper)
- ❑ INFIELD (Parking) (Seating)
- ❑ OTHER:_____

ACTIVITY:

- ❑ PASSING:
- ❑ BEING PASSED
- ❑ SUDDEN MECH. FAILURE
- ❑ NORMAL RACING
- ❑ MAINTENANCE (Fuel) (Tires) (Mechanical)
- ❑ LOADING
- ❑ UNLOADING
- ❑ HORSEPLAY
- ❑ OTHER:_____

SITUATION:

IF MECHANICAL FAILURE:

- ❑ LOST FRONT WHEEL (L) (R)
- ❑ LOST REAR WHEEL (L) (R)
- ❑ CUT TIRE
- ❑ BLOWN ENGINE
- ❑ STUCK THROTTLE
- ❑ OTHER:_____

IF NON-MECHANICAL:

- ❑ HIT MULTIPLE CAR PILEUP
- ❑ COLLIDED W/_____

  _____
- ❑ HIT BY_____

  _____
- ❑ FALL (Slip) (Trip) (Pushed)
- ❑ OTHER: _____

SURFACE:

- ❑ ASPHALT
- ❑ DIRT
- ❑ MUD
- ❑ ICE
- ❑ CONCRETE
- ❑ OTHER:_____

CONDITION:

- ❑ NORMAL
- ❑ WET
- ❑ SNOW/ICE
- ❑ IRREGULAR
- ❑ OILY
- ❑ OTHER:_____

WITNESSES:

❑ YES* ❑ NO

*If yes, use reverse side of this form to record name, phone, address.

DESCRIBE HOW ACCIDENT HAPPENED:

(Over for witness information)

(print) Title:

Completed by: Phone:

COMPLETE BOTH SIDES AND RETURN TO K&K, P.O. BOX 2338, FORT WAYNE, IN 46801-2338.

THIS SIDE TO BE COMPLETED BY TRACK REPRESENTATIVE

ACCIDENT MEDICAL INSURANCE CLAIM FORM

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 PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FOREWORD 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. THE DATA REQUESTED IS IMPERATIVE AND WILL EXPEDITE YOUR CLAIM PROCESSING.

INJURED PERSON _____

FATHER'S NAME (If Minor) _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ POLICY NO. _____

GROUP INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____

SPOUSE'S NAME (If Applicable) _____

MOTHER'S NAME (If Minor) _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ POLICY NO. _____

GROUP INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____

(Tear off and send as instructed)

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? _____

SIGNATURE _____

DATE _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVE 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 PROPER 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

Accident Report and Accident Insurance Claim Form

(NOTE: Report and Claim Form will be returned if not fully completed and signed.)

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

1. A track representative will complete the accident report (front). If the policy provides accident medical coverage and the injured party was an event participant, the form should be given to the participant or parents to complete the accident medical insurance claim form (Part II).

2. The participant or participant's parents/guardian will complete the form, detach it from the instruction page, and forward it to K&K Insurance Group, Inc.

3. IF CLAIM INVOLVES INJURY TO A SPECTATOR OR PROPERTY DAMAGE, ONLY THE ACCIDENT REPORT NEED BE COMPLETED.

To the Participant/Parent/Guardian:

IF THE MEDICAL BENEFIT IS EXCESS, YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FOREWORD 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.

K&K INSURANCE GROUP, INC.

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

Arkansas, Florida, Kentucky, Michigan, New Jersey and Pennsylvania
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 civil penalties.

California
For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. California Insurance Frauds Prevention Act 1871.2

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 a insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder 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.

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, this is a third degree felony.

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.

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

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.

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.

New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact or material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio
Any person who, with intent to defraud or knowing that he 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.

Oklahoma
Any person who knowingly & 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. (360.S. 5361.1)

Dear Participant: If you have an appointment with a doctor as the result of a sport related injury, please show this document to the doctor's insurance secretary. You should be identified as a member of the following preferred provider networks and/or their affiliates.

Dear Doctor or Provider: This document indicates that this patient is a participant in the following preferred provider networks and/or their affiliates:

The First Health Network

HYGEIA

INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT /GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.