National Federation of State High School Associations
Coaches and Officials Coverage
2019-2020

General Liability Insurance
Carrier: Scottsdale Insurance Company
Effective Date: July 1, 2019 – July 1, 2020
General Aggregate Limit: $5,000,000
Products-Completed Operations Aggregate Limit: $5,000,000
Each Occurrence Limit: $2,000,000
Personal and Advertising Injury Limit: $1,000,000
Damage to Premises Rented to You: $300,000
Premises Medical Payments: $5,000
Sexual Abuse & Molestation – Each Occurrence: $1,000,000
Sexual Abuse & Molestation – Aggregate: $2,000,000
Participant Legal Liability: $1,000,000 Coverage Endorsement
Crisis Response – Each Event/Aggregate: $25,000
Deductible: $0 (zero)

Excess Liability Insurance
Carrier: HDI Global Specialty SE
Effective Date: July 1, 2019 – July 1, 2020
Each Occurrence Limit: $1,000,000
General Aggregate Limit: $1,000,000

Blanket Accident Program
Carrier: Hartford Fire Insurance Company
Effective Date: July 1, 2019 – July 1, 2020
Benefits: Excess Accident Medical Expense Benefit

Maximum Benefit	$50,000
Deductible (Disappearing)	$250
Accidental Death and Dismemberment Maximum Benefit	$10,000
Heart & Circulatory Malfunction Maximum Benefit	$10,000
Physical Therapy – per Visit	Up to $50 Per Day
Physical Therapy– Maximum per Injury	40 Days, Limited to One Treatment Per Day
Durable Medical Equipment – Maximum per Injury	Up To $1,000 per Covered Accident
Prescription Drug – Maximum per Injury	Up To $1,000 per Covered Accident
Benefit Period	52 Weeks
Concussion	$100
Treatment by a Physician	Within 26 Hours
Concussion - Maximum	3

Covered Activities: Insured persons are covered for injury resulting from an accident which occurs directly from:

* Activities that are scheduled, sponsored, or supervised by the policyholder;
* Premises owned, leased or borrowed by the policyholder;
* Travel scheduled, sponsored or supervised by the policyholder. (accident medical coverage only)

* For officials/referees, coverage shall apply only while the member is engaging in officiating activities during regularly scheduled sports or activities competition, which includes assigning, chain crew, and attending or operating officiating camps, clinics or meetings.
* Coaches - coverage is only afforded to those members of the National Federation Coaches Association who are certified by the NFHS as having completed the National Federation Coaches Education Program.

Dissinger Reed, LLC
8700 Indian Creek Parkway, Suite 320
Overland Park, KS 66210
Phone: 800-386-9183 or 913-491-6385
Fax: 913-491-0527
email: info@dissingerreed.com
www.dissingerreed.com/nfhs

K&K INSURANCE

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

THE HARTFORD

PARTICIPANT ACCIDENT MEDICAL INSURANCE CLAIM FORM INSTRUCTIONS

National Federation of State High School Associations

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

Basic Procedures for Submitting the Accident Claim Form

1. The injured official will complete Parts I & II.

2. Have Part I signed by the game assigner. Part II needs to be signed by the injured official and forward both forms to K&K Insurance Group, Inc./Specialty Benefits, Inc. at the address below.

To the Injured Official:

Give the medical providers involved in your care, the contact information below for billing. This policy provides excess/secondary coverage, so if you have other insurance, advise the medical providers that the other insurance is primary and this policy is secondary. By giving them this information, we will be billed with the proper billing forms and your primary insurance Explanation of Benefits.

MAIL TO:

K&K INSURANCE GROUP, INC./SPECIALTY BENEFITS, INC.
Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338

Phone:(800) 237-2917
Fax:(312) 381-9077

Email: KK.PAClaims@kandkinsurance.com

K&K INSURANCE

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

THE HARTFORD

Hartford Life & Accident Insurance Company

ACCIDENT CLAIM FORM

National Federation of State High School Associations

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph:800-237-2917 | Fax: 312-381-9077 California License #0334819
email: KK.PAClaims@kandkinsurance.com
www.kandkinsurance.com

PART I
(PLEASE PRINT)

NATURE
❑ BODILY INJURY ❑ OTHER:_____

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

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

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.):_____
❑ 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:_____

WITNESSES (If known)
NAME:_____ NAME:_____
ADDRESS:_____ ADDRESS:_____
PHONE: (____) _____ PHONE: (____) _____

INSURED
NAME OF INSURED: *National Federation of State High School Officials (NFHS)*

GAME ASSIGNER
NAME: Rickey Neaves PHONE: (601) 924-6400
TITLE: Associate Director ORGANIZATION: Mississippi High School Activities Association
I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the forgoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.
SIGNATURE: Rickey Neaves DATE:_____
E-MAIL ADDRESS: rneaves@misshsaa.com

— PER POLICY PROVISIONS HEAT EXHAUSTION AND DEHYDRATION ARE NOT COVERED —

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

K&K INSURANCE GROUP, INC./SPECIALTY BENEFITS INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338

THIS FORM MUST INCLUDE THE 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 MEDICAL INSURANCE CLAIM FORM

Insured Name: *NFHS (National Federation of State High School Officials)*

Injured Official: _____

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 OFFICIAL

PART II

MEDICAL BENEFITS UNDER THIS POLICY WILL PROVIDE EXCESS COVERAGE. UPON RECEIPT OF THIS CLAIM FORM, AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN 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: _____

SOCIAL SECURITY NUMBER: _____

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: _____

SOCIAL SECURITY NUMBER: _____

SIGNATURE: _____

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.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the forgoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

SIGNED: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

FRAUD WARNING CERTIFICATION

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of 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.

For Residents of 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.

For residents of 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Virginia: Any person who, with the 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 may have violated the state law.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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 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.

For residents of Oregon: 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 material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

REV 08/2016

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution

Signature of Parent/Guardian or Adult Claimant _____ Date _____

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

PHCS

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./Specialty Benefits, 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.