

# Instructions for Reporting an Injury

1. Injured participant or parents of injured participant (if a minor) will complete the USA RUGBY INCIDENT REPORT.

2. Once INCIDENT REPORT is complete email report to USA Rugby at [insuranceclaim@usarugby.org](mailto:insuranceclaim@usarugby.org)

**\*\*\* No bills can be processed by K&K Insurance until a completed incident report has been sent to USA Rugby\*\*\***

3. You must file a claim with your family health insurance prior to filing anything under this policy. Please be sure to supply your medical provider your family health insurance information as primary coverage and the USA Rugby/K&K Insurance program information as secondary. If you provide the above information to the medical providers, they will automatically bill the primary and secondary (USA Rugby/K&K) insurance with the proper itemized billing statements and the required primary insurance Explanation of Benefits (EOB's). If you do not have family health insurance, the USA Rugby/K&K Insurance program would be your primary insurance and the medical providers should be provided with the K&K mailing information below.

4. Important \*\* If you do not have family health insurance, making USA Rugby/K&K primary coverage and your medical treatment is not an emergency please note that the following treatments require approval prior to service: Surgeries, MRI's, CT Scans and Physical Therapy. If you are having any of the above treatment you will need to make sure that your health care provider receives the attached Medical Approval Form prior to services.

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Address to submit medical statements:

K&K Insurance Group, Inc.

Claims Department – Participant Accident

PO Box 2338

Fort Wayne, IN 46801-2338

**\*\*Please note that K&K will not be able to process any medical bills without a completed incident report. You must submit an incident report to USA Rugby per the instructions above within 30 days of your injury\*\***



## USA RUGBY INCIDENT REPORT

(PLEASE PRINT)

**INJURED PERSON INFORMATION:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Employer \_\_\_\_\_ Spouse's Name \_\_\_\_\_

(If Minor)

Father's Name: \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Current Age \_\_\_\_\_  Male  Female

Are you a (choose one):  ATHLETE  COACH  OFFICIAL  OTHER \_\_\_\_\_

**TIME, PLACE AND DETAILS OF INCIDENT:**

Date of Incident \_\_\_\_\_ Time of Incident \_\_\_\_\_ AM PM

Body Part Injured: \_\_\_\_\_

Type of injury (choose one):  Laceration  Sprain/Strain  Fracture  Contusion  Concussion

Other: \_\_\_\_\_

Severity (choose one):  Report only  Minor  Serious  Critical  Fatality

Did you receive onsite care? **Y N** Were you taken by ambulance to a hospital? **Y N**

What event were you participating in at the time of the incident? \_\_\_\_\_

Was there a certified Coach at this event? **Y N** If so include name \_\_\_\_\_

What was the location of the event? \_\_\_\_\_

Describe what happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was there a witness to the incident? **Y N**

**WITNESSES:**

(If there was a witness please complete this section)

Witness name: \_\_\_\_\_

Witness name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**FAMILY HEALTH INSURANCE:**

**(Health Insurance MUST be filed prior to this policy)**

Insurance Company: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K, GLOBAL SPORTS SERVICES, OR THEIR 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 K&K, GLOBAL SPORTS SERVICES, OR THEIR 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.

**Claimant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**This section to be completed and signed by USA Rugby Certified Coach or Official:**

Club Name of injured: \_\_\_\_\_

Territory where incident occurred: \_\_\_\_\_

I ASSERT THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INCIDENT OCCURRED ON THIS DATE \_\_\_\_\_ WHILE (athlete, coach or Official name) \_\_\_\_\_ WAS PARTICIPATING IN A SANCTIONED USA RUGBY EVENT.

COACH or OFFICIAL NAME (print) \_\_\_\_\_ Title \_\_\_\_\_

COACH or OFFICIAL SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_