



OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT Yes No
 EMANCIPATED STUDENT: Yes No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: Yes No
 NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
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IS FATHER DECEASED? Yes No
 IS FATHER LEGALLY RESPONSIBLE? Yes No
 FATHER'S NAME (if injured is a minor) _____
 DATE OF BIRTH: _____
 EMPLOYED? Yes No SELF-EMPLOYED? Yes No
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? Yes No
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: (_____) _____
 CONTACT PERSON: _____
 Do you have group medical insurance coverage through your employment?
 Yes No
 If Yes, is it: Individual Family
 If No, please be advised K&K may contact your employer to verify no primary insurance is in force.
 INSURANCE COMPANY: _____
 INSURANCE COMPANY ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 POLICY NUMBER: _____
 TYPE OF PLAN: HEALTH MAINTENANCE ORGANIZATION (HMO)
 PREFERRED PROVIDER ORGANIZATION (PPO)
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
 OTHER (describe) _____

IS MOTHER DECEASED? Yes No
 IS MOTHER LEGALLY RESPONSIBLE? Yes No
 MOTHER'S NAME (if injured is a minor) _____
 DATE OF BIRTH: _____
 EMPLOYED? Yes No SELF-EMPLOYED? Yes No
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? Yes No
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: (_____) _____
 CONTACT PERSON: _____
 Do you have group medical insurance coverage through your employment?
 Yes No
 If Yes, is it: Individual Family
 If No, please be advised K&K may contact your employer to verify no primary insurance is in force.
 INSURANCE COMPANY: _____
 INSURANCE COMPANY ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 POLICY NUMBER: _____
 TYPE OF PLAN: HEALTH MAINTENANCE ORGANIZATION (HMO)
 PREFERRED PROVIDER ORGANIZATION (PPO)
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
 OTHER (describe) _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: _____ PARENT/GUARDIAN/MOTHER SIGNATURE: _____
 DATE: _____ DATE: _____

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.

SIGNED: _____ DATE: _____