Head Strong
Concussion Insurance

Wisconsin Interscholastic Athletic Association

2019-2020

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Program Resources
Program Summary

Wisconsin Interscholastic Athletic Association has secured HeadStrong Concussion Insurance: beginning with the 2019-2020 School Year.

Coverage Period:

August 1, 2019 - August 1, 2020

Eligible Person(s):

All athletes, grades ~~6-12~~ 9-12, participating in a covered activity.

Covered Activities:

Participating in activities, practice or play of interscholastic sports under the jurisdiction of the WIAA.

Interscholastic Sports Include:

Baseball, Basketball, Cross Country, Football, Golf, Gymnastics, Hockey, Soccer, Softball, Swimming & Diving, Tennis, Track & Field, Volleyball and Wrestling.

Includes traveling directly to and from a scheduled even as a representative of the school while traveling in transportation sponsored by the school.

Program Highlights Include:

- $25,000 Accident Medical Concussion Coverage (includes neurological follow up)
- $0 Deductible and no Co-pays
- $5,000 Accidental Death & Dismemberment
- Telemed Services provided, when needed
- No restrictions on specific doctors; no referrals needed for treatment
- No internal limits or specific procedure maximums
- A+ rated carrier with Financial XV backing
- $1.50 per participant (3,500 minimum participants to initiate coverage)
- Neurological follow up care - When medically necessary and billed at U&C
- Assists with high deductible primary insurance plans

HeadStrong
Frequently Asked Questions

Headstrong is an excess accident plan. What does that mean?
1. The Insurance will pay for covered charges after the primary insurance has been exhausted.
2. Also referred to as "secondary policy" – in that it will pay secondary to any primary insurance in place.
3. The insurance will also pay for any covered charges the primary insurance will not cover (including deductibles, co-pays, any other out-of-pocket charges).

How do I submit a claim?
Full details are provided in the Program Guide. You will need to fill out and submit a claim form (incident report), and Other Insurance Questionnaire to:
K&K Insurance/Specialty Benefits
1712 Magnavox Way - Ft. Wayne, IN 46804
Fax: (312) 381-9077
Phone: (800) 237-2917
Email: kk.newpaclaims@kandkinsurance.com

I have primary insurance, what policy should I give to the provider?
It is best to give the provider BOTH: primary insurance information and the K&K information for the concussion program. The provider should then work directly with K&K to bill primary insurance first, and the Headstrong Concussion Insurance second.

On the claim form: Insured Representative.Who is a Member School Administrator?
This can be a school administrator, athletic trainer, coach or another school representative. It is best to have the school representative be a person who was present at the time of the accident.

Do I need a referral to see a concussion specialist?
There are no restrictions on specific doctors, and no referral is needed.

What is the policy deductible?
The policy deductible is $0. The insurance offers first dollar coverage for concussion assessment and treatment. The insurance will pay for out-of-pocket costs remaining from the student's primary insurance (co-pay, deductible, treatment not covered), or will become the primary payor, if no other insurance is available.

I already paid the provider out-of-pocket, will the insurance reimburse me directly?
Yes. Please submit claim form, other insurance questionnaire, along with Bills and Explanation of Benefits to K&K Insurance. It is recommended to contact K&K Insurance prior to paying for services out of pocket.

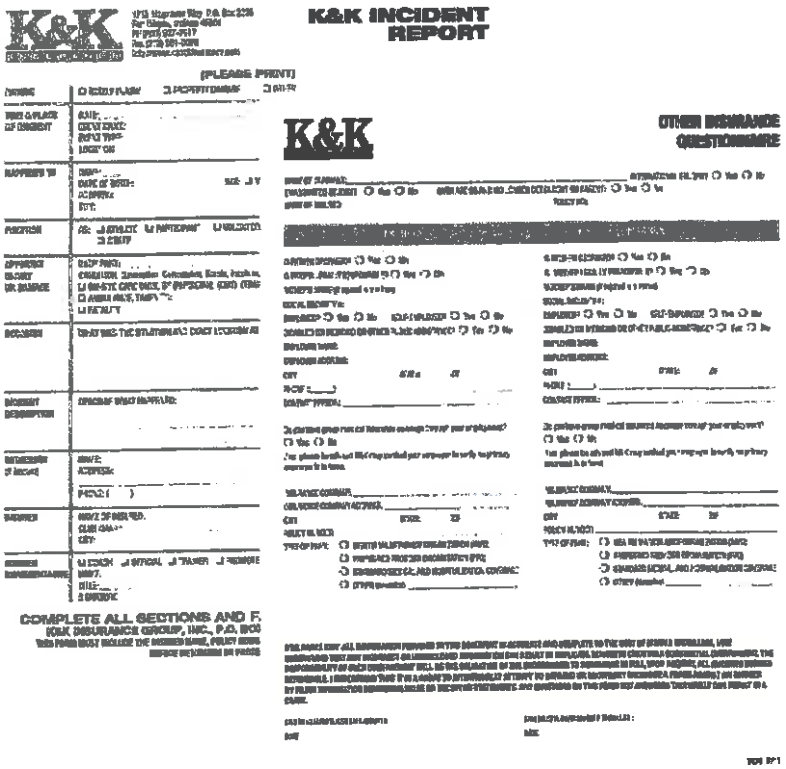
What events are "covered events?"
Participating in practice or play of sports governed and/or sponsored by the WIAA.

Program Resources
Claims

To File a Claim:

1) Incident Report
   - Must be signed by school administrator
     - Ideally a person present at time of accident
   - When possible, submit prior to treatment from provider/specialist

2) Other Insurance Questionnaire
   - Submit along with Incident Report
   - Ensures prompt claims payment
   - Minimizes paperwork for student/family
     - Submit even if:
     - No existing primary insurance
     - Primary insurance denies or does not cover provider



K&K INCIDENT REPORT

(PLEASE PRINT)

COMPLETE ALL SECTIONS AND F.

K&K

OTHER INSURANCE QUESTIONNAIRE

Wisconsin Interscholastic Athletic Association
5516 Vern Holmes Drive
Stevens Point, WI 54482

Dear Provider:

The athlete that you are treating today is a member of the _____ team, which is a participating member of the Wisconsin Interscholastic Athletic Association (WIAA).

The WIAA has provided the athlete with an excess accident medical plan that pays for expenses related to the care of a concussion injury. This plan will pay for covered charges after the athlete's primary insurance has been exhausted. K & K Insurance is the claims administrator for the excess plan and the following information is being supplied to you in an effort to assist the claimant in obtaining maximum benefits in a timely manner.

Please submit all charges through any other primary insurance first, and then submit itemized bills (HCFA-1500 or UB-92) and the primary Explanation of Benefits to:

K & K Insurance Group/Specialty Benefits
1712 Magnavox Way
Fort Wayne IN 46804
Fax: 312-381-9077

Should you have any questions or need any additional information, please feel free to call (800) 237-2917.

Thank You

K&K INSURANCE
1712 Magnavox Way P O Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
http://www.kandkinsurance.com

K&K INCIDENT REPORT

Wisconsin Interscholastic Athletic Association
Concussion Coverage

(PLEASE PRINT)

NATURE
☐ BODILY INJURY ☐ OTHER _____

TIME & PLACE OF INCIDENT
PARENT
DATE _____ TIME _____ ☐ AM ☐ PM
EVENT NAME _____
EVENT TYPE _____ CONDUCTED BY _____
LOCATION _____

HAPPENED TO
PARENT
NAME _____ SSN _____
DATE OF BIRTH _____ SEX ☐ Male ☐ Female PHONE (___) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

FUNCTION
PARENT
AS ☐ ATHLETE
☐ OTHER _____

APPARENT INJURY OR DAMAGE
PARENT
BODY PART _____
CONDITION _____
☐ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER _____
☐ AMBULANCE, TAKEN TO _____ CITY _____
☐ FATALITY

OCCASION
COACH OR TRAINER
WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____

INCIDENT DESCRIPTION
COACH OR TRAINER
DESCRIBE WHAT HAPPENED _____

OTHER SCHOOL INSURANCE
DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? ☒ Yes ☐ No
IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY: STUDENT ASSURANCE SERVICE

INSURED
NAME OF INSURED: WIAA POLICY# 6A-BAX-00000308821-00
WHSAA MEMBER SCHOOL NAME: ST. CROIX FALLS H.S. PHONE: (715) 483-2507
CITY: ST. CROIX FALLS STATE: WI

INSURED REPRESENTATIVE
☒ WHSAA Member School Administrator ☐ OTHER _____
NAME: PAUL RANDOLPH PHONE (715) 483-2507 EXT. 1305
TITLE: ATHLETIC DIRECTOR ORGANIZATION: ST. CROIX FALLS H.S.
SIGNATURE _____ DATE _____

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:
K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338
THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

*PARENT COMPLETES

K&K INSURANCE

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

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)_____

MOTHER

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:_____

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