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

SAY SOCCER INCIDENT REPORT

(PLEASE PRINT) *Due to Government regulations, Medicare Beneficiary and Social Security Number information is required for all Claimants (including children and adults). Claims submitted with incomplete information will be returned.

NATURE	❑ BODILY INJURY ❑ PROPERTY DAMAGE ❑ OTHER:______
TIME & PLACE OF INCIDENT	DATE:______ TIME:______ ❑ AM ❑ PM EVENT NAME:______ EVENT TYPE:______ SANCTIONED BY:______ LOCATION:______
HAPPENED TO	NAME:______ SSN:______ DATE OF BIRTH: ______ SEX: ❑ Male ❑ Female PHONE: ( )______ ADDRESS:______ CITY:______ STATE:______ ZIP:______ EMAIL ADDRESS:______ * ARE YOU A MEDICARE/MEDICAID BENEFICIARY? ❑ NO ❑ YES *IF YES, SOCIAL SECURITY NUMBER IS REQUIRED.
FUNCTION	AS: ❑ ATHLETE ❑ PARTICIPANT ❑ VOLUNTEER ❑ SPECTATOR ❑ BYSTANDER ❑ OFFICIAL ❑ OTHER:______
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	SAY AREA/DISTRICT:______ CLUB NAME:______ PHONE: ( )______ CITY:______ STATE:______
INSURED REPRESENTATIVE	LEAGUE REPRESENTATIVE:______ NAME:______ PHONE: ( )______ TITLE:______ ORGANIZATION:______ SIGNATURE:______ DATE:______

COMPLETE ALL SECTIONS AND MAIL OR EMAIL IMMEDIATELY TO:

SAY SOCCER NATIONAL OFFICE: 11490 Springfield Pike, Cincinnati, OH 45246

Email: JBlanton@saysoccer.org

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

SAY_SOCCER(PA)1029_10-19