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)_____

SOCIAL SECURITY #: _____

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 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) _____

SOCIAL SECURITY #: _____

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 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:_____