

INCIDENT / INJURY REPORT



**USA
GYMNASTICS**

USA Gymnastics Insurance Agency:

AMERICAN SPECIALTY INSURANCE SERVICES, INC.

PO Box 459

Roanoke, Indiana 46783-0459

(800) 566-7941 Phone

(260) 673-1189 Fax



INCIDENT/CLAIM REPORT

INJURED Gymnast Instructor Spectator Other: _____

Name: _____ Age: _____ Social Security #: _____ Sex: M F

Parent's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____

Gymnast USA Gymnastics #: _____ Level: _____

National Team Member Yes No

Club Name: _____

Club Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____

Where did accident happen? Facility Name: _____

Facility Address: _____

Meet Director: Phone: () _____

INJURY: Date of Injury: _____ Time of Injury Morning Afternoon Evening

Part of Body Injured _____ Side: Left Right Both N/A

Condition: (Sprain, Fracture, Concussion, etc.) _____

Describe how the incident occurred: _____

Estimated Limited Gymnastics 1-7 days 1-3 weeks 3 weeks +

Does injured gymnast have other insurance? Yes No If yes, Company _____

OCCASION/SANCTION # _____ EVENT LOCATION: _____

To/From Competition

Warmups

During Competition

Between Events

Clinic

Parallel Bars

Horizontal Bar

Rings

Pommel

Vault

Rhythmic

Floor Exercise

Uneven Bars

Balance Beam

Trampoline

Minitramp

Other

ACTIVITY:

Stretching/Conditioning

Mid-routine

Element Practice

Dismount/Landing

Approach

Spotting

Mount

Fall

Over-rotated

Missed, Other

Collision w/Person

Collision w/ _____

Over-rotated

Under-rotated

Non-Contact Injury

Other

SERVICE INVOLVE WITH INJURY:

N/A

Floor

Mat

Between Mats

Pit

Edge of Pit

Apparatus

Other

SPECIAL CIRCUMSTANCE: None Describe

SKILL ATTEMPTED: (describe)

Event Director Signature _____ Date _____

GYMNASTICS CLUBS

Accident Insurance Claim Form

It is important that all information requested on this claim form be furnished.

TO BE COMPLETED BY INJURED PERSON OR PARENT

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER INSURANCE AND HAS A \$500 DEDUCTIBLE AND IS LIMITED TO THOSE EXPENSES INCURRED WITHIN 104 WEEKS FROM THE DATE OF THE ACCIDENT. THIS COVERAGE IS IN EXCESS OF ANY OTHER VALID AND COLLECTIBLE HEALTH & ACCIDENT POLICY. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL. IF THERE IS NO OTHER INSURANCE, THE POLICY WILL ACT AS PRIMARY INSURANCE.

CLAIMS CANNOT BE PROCESSED WITHOUT EMPLOYER INFORMATION. TO AVOID DELAY, PLEASE COMPLETE ALL PORTIONS OF PART II.

Injured Person: _____ Spouse's Name: _____

(or parent if injured is a minor)

(or parent if injured is a minor)

Are there Medical Benefits Available from Employer?

Are there Medical Benefits Available from the Employer?

Yes No

Yes No

Employer Name: _____ Employer Name: _____

Employer Address: _____ Employer Address: _____

City: State: Zip: _____ City: State: Zip: _____

Phone () _____ Policy #: _____ Phone () _____ Policy #: _____

Group Insurance Company: _____ Group Insurance Company: _____

Insurance Company Address: _____ Insurance Company Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Social Security #: _____

Signature: _____ Date: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE AMERICAN SPECIALTY SERVICES INC. OR ITS REPRESENTATIVE 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 AMERICAN SPECIALTY SERVICES, INC. OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITALS, 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 OBTAIN THE PROPER INFORMATION TO PROCESS MY CLAIM.

Signed: _____ Date: _____

Please note: If injured person is a Minor, Signature Must be Parent of Legal Guardian

BENEFIT SUMMARY/INCIDENT REPORTING

This outline is a general reference to the coverage provided through the insurance policy or policies and is not intended to describe all of the details pertaining to the policy of insurance. It is subject to the terms, conditions, provisions, and exclusions as contained in the policy. Please consult actual policy wording for complete description and details regarding coverage.

INSURANCE BENEFITS TO ATHLETE MEMBERS:

Membership with the USA Gymnastics as an athlete member includes two types of accident insurance while the membership is in force:

- 1. Participant Accident** – This insurance covers medical expenses resulting from accidents while participating in USA Gymnastics sanctioned competition. Two important points to note are that the insurance coverage is secondary, meaning it applies only to expenses not covered by a member's primary insurance, and is subject to a \$500 deductible. (For National Team members there is no deductible). Only those expenses related to costs incurred from an injury that has a specific place and time are covered. Expenses related to "nagging" injuries where it is not certain when the injury took place are not covered under the policy. The maximum amount of coverage is \$50,000.
- 2. Catastrophic Insurance** – In the event of severe injury incurred by an athlete member during the course of a sanctioned event, the catastrophic insurance coverage is triggered. This coverage is subject to a \$50,000 deductible (covered by the participant Accident policy in #1 above) with maximum medical benefits of \$5,000,000. Claims over the \$50,000 policy limit will automatically be reported to the catastrophic insurance carrier.

WHAT TO DO IN CASE OF AN INJURY AT A SANCTIONED EVENT:

1. Notify the meet director of the injury, if they have not already been made aware.
2. Obtain from the meet director an Incident Report and Accident Claim form. The meet director is required to complete a portion of the form. Make sure he or she has completed their portion before accepting the form.
3. Fax or send a copy of the Incident Report and Accident Claim form to American Specialty.
4. If primary insurance coverage is available, file with the primary insurance carrier. For those expenses, not covered by the primary carrier, forward a copy of the Explanation of Benefits, along with copies of the ITEMIZED medical statements and a copy of the Incident and Claim form to:

American Specialty Insurance Services, Inc.
PO BOX 459
Roanoke, Indiana 46783-0459
(800) 566-7941 Phone
(260) 673-1189 Fax

If primary insurance is not available, forward a copy of the ITEMIZED medical statements along with the Incident and Claim form to the above address.

Special Note to USA Gymnastics National Team Members: In addition to coverage at sanctioned events, the above insurance coverage also applies during training. The coverage applies only to the following teams:

Men's Sr. National Team
Men's Jr. Elite National Teams
Women's Sr. International Team
Women's Jr. International Team

RSG Sr. National Team
RSG Jr. National Team
Trampoline and Tumbling Sr. National Team
Trampoline and Tumbling Jr. National Team

In the event of an injury, the coach or trainer should complete their applicable section of the same form as is used for competitive events, and provide a copy to the athlete's parent/guardian. Please note that in addition to individual primary insurance coverage that the athlete may have, the gym where the athlete trains may provide secondary coverages as well. Please complete all applicable sections of the claim form.

INCIDENT REPORT AND ACCIDENT CLAIM FORM

(Note: Report and Claim form will be returned if not fully COMPLETED and SIGNED)

How to File an Incident Report and Accident Claim form:

1. The meet director, coach or trainer will complete their portion of the form and then give the case report/claim form to the gymnast or gymnast's parent/guardian for completion.
2. The gymnast or gymnast's parent/guardian will complete the form, detach it from the instruction page, and fax it to American Specialty Insurance Services (219) 673-1291 or mail it to American Specialty Insurance Services, Inc.
3. Upon receipt of the Incident Report and Accident Claim form American Specialty Insurance Services, Inc. will contact USA Gymnastics to confirm that the participant is a registered Athlete Member.

Attach itemized physician, hospital or other provider's medical bills for accident medical expenses being claimed as well as the primary carrier's Explanation of Benefits showing payments and denials. These medical bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. Return this form to:

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