# USA GYMNASTICS SANCTIONED EVENT
# INCIDENT REPORT FORM

This form must be completed by the Meet Director of the Event.

**Injured Person Personal Information:**

Was the injured party an: ☐ Athlete ☐ Coach/judge ☐ Spectator ☐ Other Discipline: ☐ Artistic ☐ T&T ☐ Rhythmic ☐ Acrobatic ☐GFA

Gender: ☐ Male ☐ Female Athlete Level: _____ USA Gymnastics Member #: _____ National Team Member: ☐ Yes ☐ No

Name of Injured Party: _____ DOB: _____ Social Security #: _____

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

Daytime Phone: _____ Alternative Phone: _____

Parent/Guardian Name (if under 18): _____

Parent/Guardian Address: _____ City: _____ State: _____ Zip_____

Parent/Guardian Phone: _____ Email Address: _____

Does the injured party have primary insurance coverage: ☐ Yes ☐ No If yes, provide company name: _____

**Injured Person Club Information:**

Name of Club: _____ Club Phone: _____

Club Address: _____ City: _____ State: _____ Zip: _____

**Incident Details:** Sanction #: _____ Date of Incident: _____ Time of Incident: _____

Name and Address of the facility where incident occurred: _____

Meet Director Name: _____ Meet Director Phone: _____

Meet Director Email Address: _____

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

Condition of Injury (sprain, fracture, concussion, etc.): _____

Indicate Occasion of Incident: ☐ to/from competition ☐ warm-ups ☐ during competition ☐ between events

Description of Incident: _____

_____

**Indicate Apparatus if applicable:** ☐ Parallel Bars ☐ Horizontal Bar ☐ Still Rings ☐ Floor Exercise ☐ Vault ☐ Pommel ☐ Balance Beam

☐ Uneven Bars ☐ Trampoline ☐Mini-Trampoline ☐ Rhythmic Event ☐ Other (please indicate): _____

**Indicate Skill/Activity:** ☐ Stretching/conditioning ☐ Element Practice ☐ Mid-Routine ☐ Approach ☐ Spotting ☐ Dismount Landing

☐ Mount ☐ Skill Attempted please describe: _____

**Indicate Type of Incident:** ☐ Fall ☐ Over-Rotated ☐ Missed, other ☐ Collison with Person ☐ Non-Contact Injury

☐ Collision with _____ Other Special Circumstance: _____

**Surface Involved with Injury:** ☐ Mat ☐ Floor ☐ Between Mats ☐ Pit ☐ Edge of Pit ☐ Apparatus ☐ Other ☐ N/A

**Meet Director Signature: _____ Date: _____**

**Please return completed form via fax or mail to:**
**HSR -** Health Special Risk, Inc.
8400 Belleview Drive, Suite 150 • Plano, TX 75024
Phone: 972.512.5600 Toll Free: 800.328.1114 Fax: 972.512.5820

Sanction #: _____

Meet Director Name: _____

Meet Director Member #: _____

Date of Injury/Incident: _____

# USA GYMNASTICS SANCTIONED EVENT
# ACCIDENT REPORT FORM

This section should be completed by injured person (parent/guardian for minor).

**Important Notice:** This policy provides excess accident medical coverage for injuries sustained while participating in a covered activity or covered travel as defined by the policy. Medical bills must be submitted to all other valid and collectible insurance plans prior to submitting to this plan for consideration. **HSR** will consider benefits according to the terms and conditions of the policy after other available insurance has processed the claim. Please read the following to expedite the claims process.

- It is important all information requested on this claim form be furnished to avoid a delay in processing.
  - Incident Report Form to be completed by Meet Director.
  - Accident Report Form to be completed by injured person (parent/guardian for minor).
- This policy has a $500 deductible.
- Coverage is limited to eligible expenses incurred within 104 weeks from the date of injury.
- To streamline the process, please notify all doctors/hospitals of all available health insurance, as well as, the excess accident medical coverage. Provide them PAYOR # 65449 for HSR billing. This will allow the medical providers to forward the itemized bills directly to HSR.
- If you have already received treatment related to injury and did not know about this coverage, then please send all statements/itemized bills to HSR at the address shown below.
  - Note, an itemized bill should include the name of the doctor/hospital, their complete mailing address, telephone number, the date of service/treatment, the type of service/treatment and the specific itemized charges incurred. **Balance Due** statements do not include the required information to consider charges.
- In addition to the itemized bill(s) copies of the corresponding Explanation of Benefit(s) from other valid and collectible insurance showing their claim consideration are required to consider charges.

**HSR - Health Special Risk, Inc. 4100 Medical Parkway Carrollton, TX 75007**
**Phone: 972.512.5600 Toll Free: 800.328.1114 Fax: 972.512.5820**

**Injured Person Information:** Name: _____ USA Gymnastics Member #: _____

Date of Incident: _____ Parent/Guardian Name (if injured person is under the age of 18): _____

**Insurance Information:**

Do you/spouse/parent/guardian have medical/health care or is the claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does you son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If yes, name of insurance company: _____ Policy #: _____

Name of insurance company: _____ Policy #: _____

Claimant's Employer Name, Address, and Phone #: _____

Father's Employer Name, Address, and Phone #: _____

Mother's Employer Name, Address, and Phone #: _____

**IF OTHER INSURANCE OR HEALTH CARE PLAN EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER HEALTH INSURANCE PLAN EXISTS, PLEASE READ & SIGN BELOW.**

**I agree that should it be determined later there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC. to the extent of any amount collectible.**

**SIGNATURE OF PARTICIPANT/PARENT/GUARDIAN:** _____ **DATE:** _____

I authorize medical payments to physician or supplier for services described on any attached statements enclosed (if not signed, submit proof of payment).

**SIGNATURE OF PARTICIPANT/PARENT/GUARDIAN:** _____ **DATE:** _____

I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo copy of this authorization shall be considered as effective and valid as the original.

**SIGNATURE OF PARTICIPANT/PARENT/GUARDIAN:** _____ **DATE:** _____

**FRAUD STATEMENTS**

**FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Alaska and Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas, Louisiana, Maryland, West Virginia &Rhode Island: Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Connecticut:** This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

**Delaware, Idaho, Indiana**: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida: WARNING**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Georgia:** Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
   a) In any written statement;
   b) In the filing of a claim; or
   c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

**Michigan, North Dakota, South Dakota:** Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

**Minnesota;** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Nevada:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

**New Hampshire**: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico and Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be subject to prosecution for insurance fraud.

**Tennessee, Virginia, Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.