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

<table>
<thead>
<tr>
<th>INJURED</th>
<th>Gymnast</th>
<th>Instructor</th>
<th>Spectator</th>
<th>Other:</th>
</tr>
</thead>
</table>

**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 __________________________

<table>
<thead>
<tr>
<th>OCCASION/SANCTION #</th>
<th>EVENT LOCATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ To/From Competition</td>
<td>□ Parallel Bars</td>
</tr>
<tr>
<td>□ Warms</td>
<td>□ Floor Exercise</td>
</tr>
<tr>
<td>□ During Competition</td>
<td>□ Horizontal Bar</td>
</tr>
<tr>
<td>□ Between Events</td>
<td>□ Uneven Bars</td>
</tr>
<tr>
<td>□ Clinic</td>
<td>□ Rings</td>
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<tr>
<td></td>
<td>□ Balance Beam</td>
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<tr>
<td></td>
<td>□ Pommel</td>
</tr>
<tr>
<td></td>
<td>□ Trampoline</td>
</tr>
<tr>
<td></td>
<td>□ Vault</td>
</tr>
<tr>
<td></td>
<td>□ Minitramp</td>
</tr>
<tr>
<td></td>
<td>□ Rhythmic</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
</tr>
</tbody>
</table>

**ACTIVITY:**

| □ Stretching/Conditioning | □ Mid-routine |
| □ Element Practice        | □ Dismount/Landing |
| □ Approach                | □ Spotting      |
| □ Mount                   |                |

**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)

Are there Medical Benefits Available from Employer? □ Yes □ No
Employer Name: ___________________________
Employer Address: ___________________________
City: _______ State: _______ Zip: ____________
Phone ( ) _______ Policy #: _______
Group Insurance Company: ___________________________
Insurance Company Address: ___________________________
City: _______ State: _______ Zip: ____________
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) 673-1251 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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