



# PARTICIPANT ACCIDENT MEDICAL CLAIM FORM

SEND COMPLETED FORM TO:  
 American Specialty Insurance & Risk Services, Inc.  
 P.O. Box 459  
 Roanoke, IN 46783  
 (800) 566-7941 Telephone  
 (260) 673-1291 Facsimile

**This form is required to submit a Participant Accident medical claim for injuries sustained during a USA Water Ski sanctioned event.**  
 PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

<b>TO BE COMPLETED BY INJURED PARTY (OR BY PARENT/LEGAL GUARDIAN IN CASE OF A MINOR)</b>							
NAME (Last Name)	(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	MINOR:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE
						MARRIED:	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOME ADDRESS (Street)					(City)	(State)	(Zip Code)
					HOME TEL. # ( )		
OCCUPATION		NAME AND ADDRESS OF EMPLOYER			EMPLOYER'S MAIN TEL. #: ( )		
NAME OF SPOUSE (IF MARRIED)		NAME AND ADDRESS OF EMPLOYER FOR SPOUSE			EMPLOYER'S MAIN TEL. #: ( )		
NAME OF PARENT/LEGAL GUARDIAN (IF MINOR)		NAME AND ADDRESS OF EMPLOYER FOR PARENT/LEGAL GUARDIAN			EMPLOYER'S MAIN TEL. #: ( )		
NAME OF PARENT/LEGAL GUARDIAN (IF MINOR)		NAME AND ADDRESS OF EMPLOYER FOR PARENT/LEGAL GUARDIAN			EMPLOYER'S MAIN TEL. #: ( )		
USA WATER SKI MEMBERSHIP STATUS: <input type="checkbox"/> ACTIVE MEMBER <input type="checkbox"/> GUEST/BASIC SKILLS MEMBER    MEMBERSHIP #: _____							
SPORT DISCIPLINE: <input type="checkbox"/> AWSA (3 Event) <input type="checkbox"/> Eastern Region <input type="checkbox"/> Midwest Region <input type="checkbox"/> Southern Region <input type="checkbox"/> South Central Region <input type="checkbox"/> Western Region <input type="checkbox"/> AKA (Kneeboard) <input type="checkbox"/> NCWSA (Collegiate) <input type="checkbox"/> NWSRA (Ski Racing) <input type="checkbox"/> WSDA (Disabled) <input type="checkbox"/> ABC (Barefoot) <input type="checkbox"/> USW (Wakeboard) <input type="checkbox"/> NSSA (Show Ski) <input type="checkbox"/> USHA (Hydrofoil)							
TYPE OF SANCTIONED EVENT: <input type="checkbox"/> TOURNAMENT <input type="checkbox"/> PRACTICE <input type="checkbox"/> EXHIBITION <input type="checkbox"/> OFFICIALS CLINIC <input type="checkbox"/> BASIC SKILLS CLINIC <input type="checkbox"/> OTHER: _____							
DID THE INJURY OCCUR DURING A USA WATER SKI SANCTIONED EVENT?: <input type="checkbox"/> YES <input type="checkbox"/> NO    SANCTION #: _____ DID THE INJURY OCCUR WHILE TRAVELING TO/FROM THE EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO							
NAME OF EVENT:			NAME OF SAFETY/CLUB OFFICIAL OR EVENT ORGANIZER:			TEL. # ( )	
NATURE OF INJURY:			DATE OF INJURY:		TIME OF INJURY: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<b>FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:</b> A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT: _____ B. DESCRIBE WHERE ACCIDENT HAPPENED: _____ C. DESCRIBE HOW ACCIDENT HAPPENED: _____ D. WITNESS NAME: _____ TEL. #: _____ ( )							
IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN(S), INCLUDING BUT NOT LIMITED TO: GROUP OR INDIVIDUAL MEDICAL, MEDICARE, MEDICAID OR OTHER MILITARY/GOVERNMENT PLANS, OR AUTOMOBILE PLAN? <input type="checkbox"/> YES (Please list below) <input type="checkbox"/> NO							
TYPE OF INSURANCE PLAN	NAME AND ADDRESS OF INSURANCE COMPANY				POLICY NUMBER		
TYPE OF INSURANCE PLAN	NAME AND ADDRESS OF INSURANCE COMPANY				POLICY NUMBER		
<b>AUTHORIZATION TO RELEASE INFORMATION:</b> I hereby authorize the release of information related to my employment, medical, dental, physical, mental, alcohol or drug abuse history to American Specialty Insurance & Risk Services, Inc., its employees or agents for the purpose of validating and determining benefits payable under the USA Water Ski Participant Accident policy. This authorization or a photo static copy of the original shall be valid for the duration of my claim.					SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)		
<b>AUTHORIZATION TO PAY PROVIDERS:</b> I authorize payment associated with my injury directly to the medical/health care providers.					SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)		
<b>I certify that the foregoing information is true and correct.</b>			SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)			DATE	

The issuance of this form is not an admission of liability or recognition of the validity of any claim, and is without prejudice to the Company's legal rights.



# USA WATER SKI MEDICAL CLAIM FORM

## Important Claim Notice

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

**District of Columbia & Pennsylvania Residents:** 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.

**Florida Residents:** 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.

**Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other 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.

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

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

**New York Residents:** 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 Residents:** 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.

**Texas Residents:** 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.

**For All States Other Than Those Above:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. This notice does not apply in Virginia.

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**SIGNATURE OF INJURED PARTY (PARENT/LEGAL GUARDIAN IF A MINOR)**

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**Date**