

U.S. Program/Area: Date of Incident: _____

Injured Person/Party Information Date of Birth: ____/____/____ Age: _____

Name: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Gender: Male Female Social Security Number: _____ - _____ - _____

TYPE OF INJURY/ACCIDENT:

- Bodily Injury
- Property Damage
- Automobile
- Other: _____

INJURED PARTY:

- Athlete Spectator
- Volunteer Unified Partner
- Coach Property Owner
- Employee
- Other: _____

Description of Accident (If automobile accident occurred, please attach a copy of the police report). Describe how the accident occurred (attach a separate sheet if necessary): _____

Site/event where accident occurred: _____

ACCIDENT OCCURRED DURING:

- Training/Practice
- Competition
- Traveling to or from SO event
- Other: _____

TYPE OF INJURY:

- Severe cut w/ bleeding
- Less serious bruise or cut
- Break/fracture
- Concussion
- Paralysis
- Fatality
- Other: _____

DISPOSITION:

- Released to parent
- Refusal of care
- Refer to doctor
- Refer to hospital or clinic
- Medical attention
- EMS transport
- Patient requested EMS transport
- Released to personal vehicle
- Police
- Ambulance
- Report only
- Other: _____

BODY PART INJURED:

- Head
- Neck
- Torso
- Back
- Hand (L / R)
- Finger (L / R)
- Elbow (L / R)
- Shoulder (L / R)
- Leg (L / R)
- Knee (L / R)
- Thigh (L / R)
- Shin (L / R)
- Toe (L / R)
- Other: _____

SPORT:

- Alpine Skiing
- Aquatics
- Athletics
- Badminton
- Baseball
- Basketball
- Bocce
- Bowling
- Cheerleading
- Cross Country Ski
- Cycling
- Equestrian
- Figure Skating
- Floor Hockey
- Golf
- Gymnastics
- Kickball

SPORT cont.

- Power Lifting
- Relay Game
- Roller Skating
- Sailing
- Snowboarding
- Snowshoe
- Soccer
- Softball
- Speed Skating
- Swimming
- Table Tennis
- Team Handball
- Tennis
- Track & Field
- Volleyball
- Other: _____

Contact/Care Provider Information If an athlete or underage volunteer was injured, please identify care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____

Name: _____

Address: _____

Home Phone: (____) _____ - _____

Employer Name: _____

Employer Address: _____

Work Phone: (____) _____ - _____

Does the injured person have medical insurance? Yes No

If yes, insurance is provided by: Injured Person Care Provider/Responsible Party

Please provide name of Company and Policy Number: _____

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____

Daytime Phone: (____) _____ - _____

Witness #2 Name: _____

Daytime Phone: (____) _____ - _____

Special Olympics Official / Representative (other than claimant)

Name: _____

Daytime Phone: (____) _____ - _____

Signature: _____

SUBMIT ACCIDENT MEDICAL CLAIMS TO:

HEALTH SPECIAL RISK, INC. (HSR)
HSR Plaza II, 4100 Medical Parkway, Carrollton, TX 75007
Toll Free: 800.328.1114 | Fax: 972.512.5820
Email: claims@hsri.com

SUBMIT LIABILITY CLAIMS TO:

AMERICAN SPECIALTY INSURANCE
7609 W. Jefferson Blvd., Suite 150, Fort Wayne, IN 46804
Toll Free: 800.566.7941 | Fax: 260.969.4729
Email: claims@americanspecialty.com

IF INJURY WAS SERIOUS OR FATAL, IMMEDIATELY NOTIFY

AMERICAN SPECIALTY at 800.566.7941.

We provide 24/7 Emergency Claims Phone Coverage.