



Motorsports/Powerboat/PWC Claim Incident Reporting Form

1. Please fully complete this form
2. Attach itemized bills (if applicable)
3. MAIL TO: APBA 17640 East Nine Mile Road, Eastpointe, MI 48021
E-MAIL TO: APBAHQ@APBA.ORG FAX TO: 586-773-6490

PART I - POLICYHOLDER'S REPORT		POLICY NUMBER		SR2014MIP-120166
Name of Policyholder: American Power Boat Association		Address of Policyholder: Address, City, State, Zip) 17640 East Nine Mile Rd., Eastpointe, MI 48021		
Name of Injured Person:		Injured: <input type="checkbox"/> Driver <input type="checkbox"/> Pit Crew <input type="checkbox"/> Official <input type="checkbox"/> Spectator <input type="checkbox"/> Other		
Address of Injured Person:				
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Best Contact Phone #	E-Mail Address	
Track Name / Location (if different from policyholder):				
Date of Injury:		Time of Injury: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Lights		Disposition: <input type="checkbox"/> On-Site Care Only <input type="checkbox"/> Ambulance to (City) <input type="checkbox"/> Refused Treatment
Injured Body Part: Side of the Body: <input type="checkbox"/> Left <input type="checkbox"/> Right		Condition (sprain, fracture, concussion, etc.)		Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Benefits Claimed: <input type="checkbox"/> Accident-Medical <input type="checkbox"/> Dental <input type="checkbox"/> Accidental Death <input type="checkbox"/> Specific Loss <input type="checkbox"/> Disability*				
*If claiming for disability benefits we need the name, address and a telephone number for your employer				
Type: <input type="checkbox"/> Oval <input type="checkbox"/> Road Course <input type="checkbox"/> Drag Racing <input type="checkbox"/> Motorcycle <input type="checkbox"/> Other <input type="checkbox"/> Type of Event <input type="checkbox"/> Boat <input type="checkbox"/> PWC <input type="checkbox"/> Other <input type="checkbox"/> Event Class				
Occasion: <input type="checkbox"/> Pre-Race <input type="checkbox"/> Pit Stop <input type="checkbox"/> During Race: <input type="checkbox"/> Start <input type="checkbox"/> Early <input type="checkbox"/> Mid <input type="checkbox"/> Late <input type="checkbox"/> Finish <input type="checkbox"/> After Race				
Description of Accident (Attach a Separate sheet if necessary):				
Witnesses: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, complete witness information below)				
Name / Address / Best Phone # of Witness:				
SIGNATURE OF WITNESS				
SIGNATURE OF POLICYHOLDER REPRESENTATIVE		TITLE	DATE _/_/___	

PART II – STATEMENT OF CERTIFICATION (required)

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York Claimants: 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. (PURSUANT TO 11 NYC RR86)

Signature of Parent/
Guardian/Claimant (required) _____ Date _____



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PART III – OTHER INSURANCE STATEMENT

Do you/spouse/parent 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 your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

YES NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

Father/Guardian Name / Address / Best Phone #:

Mother/Guardian Name / Address / Best Phone #:

PART IV – AUTHORIZATION TO RELEASE INFORMATION TO PROVIDER

I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha Insurance Company or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE: _____ DATE _____

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