Motorsports/Powerboat/PWC
Claim Incident Reporting Form

1. **Please fully complete this form**
2. **Attach itemized bills (if applicable)**
3. **Mail To:**
   Special risk Services
   P.O. Box 31156, Omaha, Nebraska 68131
   1(800) 524-2324 or specialrisk.claims@mutualofomaha.com

Copy to: RH Felsen at hawkrace@aol.com
or Fax: 516.466.9663

PART I - POLICYHOLDER'S REPORT					**POLICY NUMBER** SR2014MI-P-120166
Name of Policyholder: AMERICAN POWER BOAT ASSOCIATION					**Address of Policyholder:** Address, City, State, Zip) 17640 East Nine Mile Rd., Eastpointe, MI 48021-0377
Name of Injured Person:	**Injured:** ☐ Driver	☐ Pit Crew	☐ Official	☐ Spectator	☐ Other
Address of Injured Person:					
Gender: ☐ M ☐ F	Date of Birth	**Best Contact Phone #**	**E-Mail Address**		
Track Name / Location (if different from policyholder):					
Date of Injury:	**Time of Injury:** ☐ Morning ☐ Afternoon ☐ Evening ☐ Lights		**Disposition:** ☐ On-Site Care Only ☐ Ambulance to (City) ☐ Refused Treatment		
Injured Body Part: **Side of the Body:** ☐ Left ☐ Right	**Condition** (sprain, fracture, concussion, etc.)		**Fatality:** ☐ Yes ☐ No		
Type of Benefits Claimed: ☐ Accident-Medical ☐ Dental ☐ Accidental Death ☐ Specific Loss ☐ Disability*					
*If claiming for disability benefits we need the name, address and a telephone number for your employer					
Type: ☐ Oval ☐ Road Course ☐ Drag Racing ☐ Motorcycle ☐ Other ☐ Type of Event ☐ Boat ☐ PWC ☐ Other ☐ Event Class					
Occasion: ☐ Pre-Race ☐ Pit Stop ☐ During Race: ☐ Start ☐ Early ☐ Mid ☐ Late ☐ Finish ☐ After Race					
Description of Accident (Attach a Separate sheet if necessary):					
Witnesses: ☐ Yes ☐ 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** ☐ **NO**

If Yes: Name of Insurance Co:	Policy #
Name of Insurance Co:	Policy #

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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