USA GYMNASTICS.

USA GYMNASTICS SANCTIONED EVENT INCIDENT REPORTING & SECONDARY INSURANCE BENEFIT SUMMARY

This outline is a general reference to coverage provided through the insurance policy and/or policies and is not intended to describe all details pertaining to the secondary insurance policy. It is subject to terms, conditions, provisions and exclusion as contacted in the policy. Please consult actual policy wording for complete description and details regarding coverage.

Insurance Benefits to Athlete Members:

Member within USA Gymnastics as an athlete member includes two types of accident insurance while membership is in force:

1. **Participant Accident:** This insurance covers medical expenses resulting from accidents while participating in a USA Gymnastics sanctioned event.
   a. Insurance coverage is secondary, and applies only to expenses not covered by a member's primary insurance.
   b. It is subject to a $500 deductible (USA Gymnastics National Team members no deductible is required)
   c. Only expenses related to the costs incurred from an injury that has a specific place and time are covered
   d. Expenses related to "nagging" injuries, where it is not certain when the injury took place are not covered under the policy
   e. The maximum amount of coverage is $50,000.
2. **Catastrophic Insurance:** Catastrophic insurance coverage is triggered in the event of a severe injury to an athlete member during a sanctioned event.
   a. The coverage is subject to a $50,000 deductible (covered by the participant accident policy listed above in point 1)
   b. Maximum medical benefits of $5,000,000.
   c. 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 Sanction Event:

1. Immediately notify the Meet Director of the event
2. Obtain an Incident Report Form and an Accident Claim Form from the meet director.
   a. **Incident Claim Report:** This form must be completed by the meet director while onsite. It is imperative that the meet director sign the form and provide a copy of the incident claim report to the injured person
   b. **Accident Claim Report:** This form must be completed by the injured person or parent/guardian if the injured person in under the age of 18
3. Send both a copy of the Incident Claim Report and Accident Claim Report to American Specialty Insurance Services, Inc.
4. If primary insurance coverage is available, file with the primary insurance company.
5. Expenses not covered by the primary should be forwarded to American Specialty Insurance, along with a copy of the explanation of benefits, and copies of the ITEMIZED medical statement, physician and hospital bills.
6. If primary insurance is not available, forward a copy of the **ITEMIZED** medical statement, physician and hospital bills and a copy of the incident and accident claim reports.

Please note, any and all medical bills must show the patient's name, condition (diagnosis), type of treatment provided, and date the expenses and charges incurred.

Send Incident Claim Report, Accident Claim Report and any other Medical Statements to:
American Specialty Insurance Services, Inc.
7609 W. Jefferson Blvd. Ste 150, Fort Wayne, IN 46804
Fax: 260.969.4729 • Phone: 800.566.7941

American Specialty Insurance Services Inc., will contact USA Gymnastics upon receipt of the Incident Report Form and Accident Claim Report forms to confirm that the injured person is/was a current member of USA Gymnastics at the time of the incident.

Special Note Regarding USA Gymnastics National Team Members:

In addition to coverage at sanctioned events, the above insurance also applies during training.
This coverage applies to the following teams:

- Men's Jr. & Sr. National Team
- Women's Jr. & Sr. National Team
- Rhythmic Jr. & Sr. National Team
- Trampoline & Tumbling Jr. & Sr. National Team
- Acrobatic Jr. & Sr. National Team

In the event of an injury to a national team member during training, the coach and/or trainer should complete the accident/injury report forms, and provide a copy of the completed form to the parent/guardian of the athlete.

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USA GYMNASTICS SANCTIONED EVENT INCIDENT REPORT FORM

This form must be completed by the Meet Director of the Event

Injured Person Personal Information:

Was the injured party an: ☐ athlete ☐ coach/judge ☐ spectator ☐ other Discipline: ☐ Artistic ☐ T&T ☐ Rhythmic ☐ Acrobatic ☐ GfA

Gender: ☐ male ☐ female Athlete Level: _____ USA Gymnastics Member #: _____ USA Gymnastics National Team Member: ☐ yes ☐ no

Name of Injured Party: _____ D.O.B.: _____ Social Security #: _____

Address: _____ City _____ State _____ Zip _____

Daytime Phone _____ Alternative Phone _____

Parent/Guardian Name (if under 18): _____

Parent/Guardian Address: _____ City _____ State _____ Zip _____

Parent/Guardian Phone: _____ Email Address: _____

Does the injured party have primary insurance coverage: ☐ yes ☐ no, If yes, provide company name _____

Injured Person Club Information:

Name of Club: _____ Club Phone: _____

Club Address: _____ City _____ State _____ Zip _____

Incident Details:

Sanction #: _____ Date of Incident: _____ Time of Incident: _____

Name and Address of the Facility Where Incident Occurred: _____

Meet Director Name: _____ Meet Director Phone: _____

Meet Director Email Address: _____

Body Part Injured: _____ Side of Body: ☐ left ☐ right ☐ both ☐ NA

Condition of Injury (sprain, fracture, concussion etc..) _____

Indicate Occasion of Incident: ☐ to/from competition ☐ warm-ups ☐ during competition ☐ between events

Description of Incident: _____

_____

Indicate Apparatus if applicable

☐ parallel bars ☐ horizontal bar ☐ still rings ☐ floor exercise ☐ vault ☐ pommel ☐ balance beam ☐ uneven bars

☐ trampoline ☐ mini trampoline ☐ rhythmic event ☐ Other, please indicate: _____

Indicate Skill/Activity

☐ stretching/conditioning ☐ element practice ☐ mid-routine ☐ approach ☐ spotting ☐ dismount landing ☐ mount

☐ Skill Attempted please describe: _____

Indicate Type of Incident

☐ fall ☐ over-rotated ☐ under-rotated ☐ missed, other ☐ collision with person ☐ non-contact injury ☐ collision with _____

☐ Other Special Circumstance: _____

Service Involved with Injury

☐ mat ☐ floor ☐ between mats ☐ pit ☐ edge of pit ☐ apparatus ☐ other ☐ n/a

Meet Director Signature required: _____

Date: _____

Please return completed form via fax or mail to:

America Specialty Insurance Services Inc. • 7609 W. Jefferson Blvd. Ste 150, Fort Wayne, IN 46804

Fax: 260.969.4729 • Phone: 800.566.7941

Sanction Number _____

Meet Director Name _____

Meet Director Member Number _____

Date of Injury/Incident _____

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USA GYMNASTICS SANCTIONED EVENT
ACCIDENT INSURANCE CLAIM FORM

This form must be completed by the injured person, or parent/guardian of the injured person

Important Notice:

- It is important that all information requested on this claim form be furnished.
- Coverage under the policy is excess over all other insurance
- This policy has a $500 deductible
- Coverage is limited to those expenses that incurred within 104 weeks from the date of the accident.
- Coverage is in excess of any other valid and collectible health and accident policy.
- This claim should be submitted to the insurance company providing coverage to you through your own and/or parent/guardian personal health plan, and/or your employer and/or governmental health plan.
- Coverage will occur after other insurance benefits have been submitted.
- When making claim, please submit a copy of primary insurance explanations.
- If your insurance company denies benefits, send a copy of their denial.
- If there is no insurance, this policy will act as primary insurance.
- Claim cannot be processed without employer information.
- To avoid processing delays, please complete all portions of this claim form

Injured Person Information:

Name: _____ Injured Person USA Gymnastics Member Number: _____

Date of incident: _____ Parent/Guardian Name *(if injured person is under the age of 18)* _____

Insurance Information:

Is there Medical Benefits Available from Employer? ☐ yes ☐ no

Insurance Policy Holder Name: _____

Policy Holder Address: _____ City _____ State _____ Zip _____

Phone _____ Social Security #: _____

Policy Holder Signature: _____

Group Insurance Company Name: _____ Policy #: _____

Insurance Company Address: _____ City _____ State _____ Zip _____

Employer Name: _____

Employer Address: _____ City _____ State _____ Zip _____

Employer Phone: _____ Policy # _____

I waive any provision to law to the contrary and hereby authorize American Specialty Services Inc., or it's 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, prescription, or treatment and copies of all hospital, 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.

Injured Person Signature: _____ Date: _____

Please note: If injured person is a minor, signature must be that of a parent/guardian.

Please return completed form via fax or mail to:

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