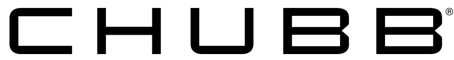

Administrative Concepts Inc
P.O. Box 4000
Collegeville, PA 19426-9000

Jockey On Track Accident Program

Chubb Group of Insurance Companies

FIRST REPORT OF ACCIDENT -CLAIM INFORMATION FORM

*POLICYHOLDER NAME:*____ *POLICY#:* _______________________________

BASED ON THE NEW MEDICARE REQUIREMENTS, WE WILL NEED THE FOLLOWING INFORMATION ON THE JOCKEY ACCIDENT REPORT, IN ORDER TO PROCESS THE CLAIM. THIS INFORMATION WILL BE USED FOR REPORTING PURPOSES ONLY.

Injury Date:		**Injured Person:**	☐ **Jockey** ☐ **Exercise Rider** ☐ **Other**			**Race #**	
Name:		☐ **F** ☐ **M**	***DOB:**			***Social Security #**	
Address:		**City**		**State**		**Zip/Postal Code:**	
Phone:		**Email:**				***Is Injured Person a USA Citizen?** Y/N:	

DESCRIPTION OF ACCIDENT

Body Part Injured		☐ On Site First Aid Only	☐ Pursue Further Treatment
☐ Transported to Hospital	Ambulance Transport To:	☐ NO INJURY	☐ Serious Injury
Describe how Injury occurred:			

Track/ Surface condition:	☐ Synthetic ☐ Dirt ☐ Firm ☐ Hard ☐ Soft ☐ Muddy ☐ Wet ☐ Yielding
Location of Accident:	☐ Paddock ☐ Stable ☐ Exercise Facility ☐ Horse Path ☐ Other
If on Race Course, did accident happen at:	☐ 1st Turn ☐ 2nd Turn ☐ 3rd Turn ☐ Final Turn ☐ Chute ☐ Backstretch ☐ Rail ☐ Prior to Gate ☐ Entering Gate ☐ In Gate ☐ Leaving Gate
How many horses involved in accident?	Was injured person thrown from horse? ☐ YES ☐ NO
Was helmet worn? ☐ YES ☐ NO	Was Safety Vest worn? ☐ YES ☐ NO Special Circumstances ? ☐ Drugs? ☐ Intoxication?

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. ☐ YES ☐ NO

Policy Holder Signature:		**Date:**	
Jockey Signature:		**Date:**	
Form Prepared by:		**Date:**	

CALIFORNIA: For your protection, California law requires the following to appear on this form: 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 residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.