POWERBOAT/PWC
Claim Incident Reporting Form

1. **Please fully complete this form**
2. **Attach itemized bills (if applicable)**
3. **MAIL TO: APBA 17640 E 9 Mile Rd. Eastpointe, MI 48021**
   EMAIL 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:** 17640 East Nine Mile Rd., Eastpointe, MI 48021	
Name of Involved Person:	**Involved:** ☐ Driver ☐ Pit Crew ☐ Official ☐ Spectator ☐ Other	
Address of Involved Person:		
APBA Member Type: ☐ Racing ☐ Non-Racing ☐ Associate ☐ Kids Crew ☐ Single Event ☐ NONE	**APBA Member #**	
Gender: ☐ M ☐ F	**Date of Birth:**	**Best Contact Phone #** / **E-Mail Address:**
Location:		
Date of Incident:	**Time of Incident:** ☐ Morning ☐ Afternoon ☐ Evening	**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: ☐ Accidental-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: ☐ Closed Course ☐ Marathon ☐ Drag ☐ PWC ☐ Event Class ☐ Other	**Category:** (if necessary)	**Class:** (if necessary)
Occasion: ☐ Pre-Race ☐ Pit Stop During Race: ☐ Start ☐ Early ☐ Mid ☐ Late ☐ Finish ☐ After Race ☐ Other: (please explain)		
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 FRAUDLENT INSURANCE ACT, WHICH IS A CIME 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 _____

POWERBOAT/PWC

Claim Incident Reporting Form

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 or 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 _____