VAN GUNDY INSURANCE

Insure with confidence.

COMPLETING THE CLAIM FORM FOR:

On Track Accident Policy # 64779457+ 3 digit location number
Ohio Excess Track Accident Policy # 64779458
Fair Track Accident Policy # 99051028 + 3 digit location number

Injured Driver/Trainer Completes:

- The section: "Claimant Completes this Section" on the front.
- "Assignment of Benefits" *on the back side of the claim form.*

Track Official Completes:

- Certification By Track Official at bottom of front side

Doctor Completes (If there is disability involved)

- "Attending Physician's Statement" on the back.

SEND THE COMPLETED CLAIM FORM TO:

Gail McNeely
Van Gundy Insurance
101 S. Towanda Avenue
Normal, IL 61761

Once the initial claim has been filed, the claimant will receive a letter from ***Health Special Risk, Inc. (HSR)*** providing the name and address of the person handling the claim.

Contact Gail McNeely 309/452-1156, email at gmcneely@vangundy.com or fax: 309/452-7500 if you have any questions.

THANK YOU!

3/20/2018

CHUBB INSURANCE

VAN GUNDY AGENCY, 101 S. Towanda Ave., Normal, IL 61761, Phone (309) 452-1156/Fax (309) 452-7500

ON TRACK DRIVER/TRAINER ACCIDENT INSURANCE
CLAIM FORM
Policies 64779457, 64779458, 99051028 & 99066913

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL, THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

CLAIMANT COMPLETES THIS SECTION

Date of Accident _____

Track Name & Address _____

Claimant's Name _____ Birth Date _____

Social Security Number _____ Email Address _____

Address _____ City _____ St _____ Zip Code _____

Telephone Number (_____) _____ Cell Number (_____) _____

Occupation (Circle) Driver Trainer Driver and Trainer USTA License # _____

Name & Address of Other Employment _____

Describe Where & How Accident Occurred _____

_____

Nature of Injury _____

Name & Address of Physician First Consulted and Other Physicians Consulted (Attach add'l sheet if needed)

_____

This information is true and complete to the best of my knowledge.

Claimant's Signature _____ **Date** _____

CERTIFICATION BY TRACK OFFICIAL

This is to certify that _____ was injured on _____ while engaged as a
Claimant's Name Date of Accident

_____. The accident occurred _____
Trainer or Driver Explanation of Accident

_____

Print Name: _____ Signature: _____ Title: _____

Date: _____ Telephone: (___) _____ Fax: (___) _____

ASSIGNMENT OF BENEFITS (CLAIMANT COMPLETES)

I authorize payment of medical benefits to physicians and/or providers for services rendered

I hereby authorize any hospital, physician, and other person/s who have attended me or examined me to disclose, when requested to do so by Chubb Insurance or its representative, any or all information with respect to any illness or injury, medical history, consultation, prescription or treatment, and to provide copies of all hospital and medical records. A copy of this authorization shall be considered as effective and valid as the original

Claimant's Signature Date

ATTENDING PHYSICIAN'S STATEMENT

PatientsName_____

Nature of Injury (Describe complications, if any)_____

_____

On what date did the patient first consult you for this condition?_____

Has patient ever had same or similar condition? ____No ____ Yes (If "yes" give date and describe)_____

_____

Describe any disease or infirmity affecting present condition._____

_____

Patient Hospitalized? _____No _____Yes (If "yes" give name/address of hospital)_____

_____

Patient was or will be temporarily totally disabled from training and/or driving? _____ No _____Yes

If "yes" give dates: From_____, 20____ Through_____, 20____

Patient was or will be temporarily totally disabled from ANY occupation. _____No _____Yes

If "yes" give dates: From_____, 20____ Through_____, 20____

Expected Return to Work Date _____, 20____

Comments

_____

Attending Physician's Signature Print Physician's Name Date

_____(____)_____

Physician's Address Telephone

Every 4 weeks we will request an update on your disability status from you and it is your reponsibility to obtain this from your physician as we will not do this on your behalf. This is required in order to prevent a delay in payment.

Return completed copy to:

Van Gundy Insurance

FAX: (309)452-7500

PHONE: (309) 452-1156

101 S. Towanda Avenue, Normal, IL 61761

IMPORTANT NOTICE

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: 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 civil fines and criminal penalties.

Notice to 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.

Notice to Ohio Claimants: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Claimants: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

Notice to Pennsylvania 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 subjects such person to criminal and civil penalties.

Notice to Virginia Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.