Chubb Insurance

VAN GUNDY INSURANCE, 101 S. Towanda Avenue, Normal, IL 61761

On Track Driver/Trainer Accident Insurance Application

Certificate No. 99051028-852

Named Insured/Track: **Ohio Harnesss Horsemen's Association**
2237 Sonora Dr, Grove City, OH 43123-2903
Renee Mancino (614) 221-3650 Fax: (614) 22-8726

Driver/Trainer Track Accident Benefits	
$ **10,000**	Accidental Death & Dismemberment (loss must occur within 1 year of accident)
$**250,000**	Accident Medical Expense with **$0 deductible per claim** (52 Weeks Benefit Period)
$ **125**	Weekly Disability (104 Weeks Benefit Period)

Driver/Trainer Matinee/Fair Dates covered: May 22, 2022 – Oct 3, 2022

Outrider Track Accident Benefits	
$ **10,000**	Accidental Death & Dismemberment (loss must occur within 1 year of accident)
$ **100,000**	Accident Medical Expense with **$0 deductible per claim** (52 Weeks Benefit Period)
$ **200**	Weekly Disability (104 Weeks Benefit Period)

Outrider Matinee/Fair Dates covered:_____

Outrider Number times Rate = Premium Not taken in 2022

PREMIUM PAYMENT TOTAL

TRACK ACCIDENT - TOTAL PREMIUM DUE	$
OUTRIDER ACCIDENT - TOTAL PREMIUM DUE	$
DUE WITH APP	**$**

Make check payable to and mail with application to VAN GUNDY INSURANCE

Check Amount Enclosed: $_____ Date: May 18, 2022

X Renee Mancino X_____

Official Signatures of Track Officials whose certification of injury is to be recognized by the insurance company.

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. All subsequent inquiries and doctor's reports should go to that person.

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

THANK YOU!

7/2/2014

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

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

Track Name & Address **Date of Accident**

Claimant's Name Birth Date Social Security Number

Street Address/Mailing Address/Apt. No.

City State Zip Code (___)_____ Telephone 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

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.