



## WSIB Motorsports Insurance

Listed below are important instructions and comments about filing a claim.

### YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim.

**Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**

2. You will receive a phone call within 2 business days from the time your claim form is received by **HSR**.
3. The claim form must be signed by a policyholder representative (i.e. racing supervisor or track owner).
4. Only one claim form for each accident needs to be submitted.
5. Once completed, make a photocopy for your records, and mail to the address shown below.
6. **DO NOT** assume that anyone else will mail this claim form to **HSR** for you.

### YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to **HSR** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for and the specific itemized charges incurred.
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. “Balance Due” statements do not contain sufficient information to complete your claim. Mailing **HSR** “Balance Due” statements will only delay the processing of your claim.

### EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance **Explanation of Benefits (EOB)** which is the statement you will receive from your primary insurance explaining what was paid or denied, and the reason(s) why.
4. **HSR** will not be able to consider your claim without this information.

If you have any questions, please contact Alathia Humphrey at **HSR** via e-mail at [WSIB@hsri.com](mailto:WSIB@hsri.com) or our toll free number (888) 747-8728. Customer Service is available from 8:00 AM thru 5:00 PM central time, Monday- Friday. You may also forward any documents by fax to (972) 512-5838.

**Health Special Risk, Inc.**  
**4100 Medical Parkway**  
**Carrollton, TX 75007**



1. PLEASE FULLY COMPLETE THIS FORM  
 2. ATTACH ITEMIZED BILLS  
 3. MAIL TO HSR  
 E-mail : WSIB@hsri.com

HSR Plaza II  
 4100 Medical Parkway  
 Carrollton, Texas 75007  
 Phone: (888) 747-8728 Fax: (972) 512-5838

Variable – Claim/Incident Report  
 Policy Number: \_\_\_\_\_

**PART I – POLICYHOLDER’S REPORT**

1. Name of Policyholder:		2. Address of Policyholder: Street _____ City _____ State _____ Zip _____			
3. Name of Injured Person:			4. Injured: <input type="checkbox"/> Driver <input type="checkbox"/> Pit Crew <input type="checkbox"/> Official <input type="checkbox"/> Spectator <input type="checkbox"/> Other _____		
5. Address of Injured Person: Street _____ City _____ State _____ Zip _____					
6. Social Security Number: - -	7. Sex: <input type="checkbox"/> F <input type="checkbox"/> M	8. Date of Birth: _ / _ / _	9. Best Contact Phone Number:		10. E-Mail:
11. Track Name/Location : <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor			12. Sanctioned By:		
13. Date of Injury:	14. Time of Injury: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Lights		15. Disposition: <input type="checkbox"/> On-Site Care Only <input type="checkbox"/> Ambulance to (city) _____		
16. Injured Body Part:		17. Condition (sprain, fracture, concussion, etc.):		18. Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Type: <input type="checkbox"/> Road Course - <input type="checkbox"/> Club Racing <input type="checkbox"/> Other _____ <input type="checkbox"/> Motorcycle <input type="checkbox"/> School <input type="checkbox"/> Kart - <input type="checkbox"/> Sprint <input type="checkbox"/> Enduro <input type="checkbox"/> Ride & Drive <input type="checkbox"/> Other _____					
20. Occasion: <input type="checkbox"/> Pre-Race <input type="checkbox"/> Pit Stop <input type="checkbox"/> During Race - <input type="checkbox"/> Start <input type="checkbox"/> Early <input type="checkbox"/> Mid <input type="checkbox"/> Late <input type="checkbox"/> Finish <input type="checkbox"/> Practice <input type="checkbox"/> Time Trials <input type="checkbox"/> Heat <input type="checkbox"/> Between Races <input type="checkbox"/> After Races				21. Location: <input type="checkbox"/> Loading Area <input type="checkbox"/> Turn # _____ <input type="checkbox"/> Pits <input type="checkbox"/> Other _____	
22. Activity: <input type="checkbox"/> Passing <input type="checkbox"/> Being Passed <input type="checkbox"/> Maintenance - <input type="checkbox"/> Fuel <input type="checkbox"/> Tires <input type="checkbox"/> Mechanical <input type="checkbox"/> Normal Racing <input type="checkbox"/> Sudden Mechanical Failure <input type="checkbox"/> Loading/Unloading <input type="checkbox"/> Horseplay <input type="checkbox"/> Other _____					
23. Situation: If Non- Mechanical Failure <input type="checkbox"/> Collided with _____ <input type="checkbox"/> Hit multiple car pile-up <input type="checkbox"/> Fall - <input type="checkbox"/> Slip <input type="checkbox"/> Trip <input type="checkbox"/> Pushed <input type="checkbox"/> Hit by _____ <input type="checkbox"/> Other _____ If Mechanical Failure <input type="checkbox"/> Lost Front Wheel - <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Cut Tire <input type="checkbox"/> Lost Rear Wheel - <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other _____ <input type="checkbox"/> Blown Engine <input type="checkbox"/> Stuck Throttle					
24. Surface: <input type="checkbox"/> Asphalt <input type="checkbox"/> Ice <input type="checkbox"/> Dirt <input type="checkbox"/> Concrete <input type="checkbox"/> Mud <input type="checkbox"/> Other _____		25. Condition: <input type="checkbox"/> Normal <input type="checkbox"/> Irregular <input type="checkbox"/> Wet <input type="checkbox"/> Oily <input type="checkbox"/> Snow/Ice <input type="checkbox"/> Other _____			
26. Describe How Accident Happened:  Witness: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, complete witness information)					
27. Name of Witness:			28. Witness Phone Number (including area code):		
29. Address of Witness: Street _____ City _____ State _____ Zip _____					
30. SIGNATURE OF POLICYHOLDER REPRESENTATIVE			31. TITLE		32. DATE

**PART II – 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  NO

If Yes: Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_  
 Name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.  
 IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC., or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
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**AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## **FRAUD STATEMENTS**

**GENERAL:** 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.

**ALASKA, ARKANSAS, IDAHO, INDIANA:** Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

**ARIZONA:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**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.

**COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DELAWARE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**DISTRICT OF COLUMBIA RESIDENTS:** WARNING It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY:** 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.

**MARYLAND:** Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW HAMPSHIRE:** 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.

**NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW MEXICO:** 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.

**NEW YORK:** 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.

**OHIO:** Any person, with 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.

**OREGON:** Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

**PENNSYLVANIA:** Any person 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 act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE:** 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.

**TEXAS:** 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.

**VIRGINIA:** 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 may have violated state law.