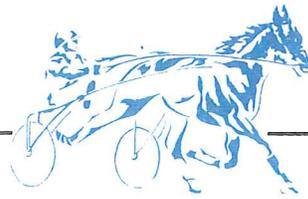




**VAN GUNDY**  
INSURANCE



*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](mailto: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**

<b>Track Name &amp; Address</b>		<b>Date of Accident</b>	
<b>Claimant's Name</b>		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.			
<b>Claimant's Signature</b>		<b>Date</b>	

**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.