# HSR

*Health Special Risk, Inc.*

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
1-877-534-PONY (7669)
(Toll Free Number)

MultiPlan **Call 800-557-6794 for Facilities Referral**

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

## PART I – NHSRA WRANGLER DIVISION PROOF OF LOSS

**Policy Number T5MP-P-50676**

**STATE** _____

**N.H.S.R.A. Member No.** _____

**Type of activity-All approved (Check one)**
**Safety Seminar** _____ **State Finals** _____
**Instructional Clinic** _____ **National Finals** _____
**Qualifying Rodeo** _____

| 1. NAME OF INSURED PERSON | 2. SOCIAL SECURITY NUMBER - - | 3. SEX __F __M | 4. BIRTHDAY ___/___/___ |
|---|---|---|---|

**5. ADDRESS OF INSURED PERSON**
Street City State Zip

**6. PARENTS' NAME, ADDRESS AND PHONE NUMBER (INCLUDE AREA CODE)**

| 7. DATE OF ACCIDENT | 8. DATE OF FIRST TREATMENT & NAME OF PHYSICIAN | 9. PLACE WHERE ACCIDENT OCCURRED (Name of town & arena) |
|---|---|---|
| | | |

**10. NATURE OF INJURY (INDICATE PART OF BODY INJURED - SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)**

**11. DESCRIBE HOW ACCIDENT OCCURRED - GIVE ALL POSSIBLE DETAILS - MUST BE A BODILY INJURY DUE TO ACCIDENT**

**12. NAME OF RODEO ACTIVITY/EVENT YOU WERE PARTICIPATING IN WHEN INJURED**

## PART II – OTHER INSURANCE STATEMENT

1. Do you have other medical insurance? YES_____ NO_____
If Yes, please furnish the following information:

Name of Policyholder (Parent-Guardian-Athlete) Policy Number Social Security Number

Name of insurance carrier, address, and phone number.

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATIONS 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 |
|---|---|---|
| | | |

## AUTHORIZATION TO PAY BENEFITS TO PROVIDER

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

**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 photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE_____ DATE_____

## Rodeo Secretary Verification

I hereby verify that the above member participated in the _____ Rodeo or Activity on (date) _____ during which he alleges he was injured.

_____
Rodeo Secretary