



ZURICH[®]

Policyholder: U.S. Ski & Snowboard
 Policy Number: MCB3031987

Mail/Email/Fax claims to:
 K&K Insurance/Specialty Benefits
 P.O. BOX 2338
 Ft. Wayne, IN 46801
 Fax: (312) 381-9077 Toll Free: (800) 237-2917
 Email: KK.PAClaims@kandkinsurance.com

**Non-National Team - Class II
 Athlete, Staff, Official, Attendee**

Official Information

Name of Official Completing form (with no relationship to claimant):	
Official Email:	Official Phone Number:
Name of Technical Director onsite:	
Technical Director Email:	Technical Director Phone Number:

Injured Person Information

Member / Injured Party Name:		Date of Birth:
Member / Injured Party Email:		Member / Injured Phone Number:
Mailing Address:		
Parent Name (if Minor):	Parent Email:	
	Parent Phone Number:	
Club Contact/Coach Name:	Club Contact/Coach Email:	
	Club Contact/Coach Phone Number:	
Club Affiliation:	USSS Member Number:	Member Type:
Health Insurance Carrier:	Policy Number:	
	Group Number:	

Incident Details

Date of Accident:	Ski Area / Location:
Incident Location:	Event Name:
Weather Conditions:	Sanctioned Event Type:
Surface:	Mechanism of Injury:
Discipline:	Classification of Injury:



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<p>Body Part Injured 1</p> <p><input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Hip <input type="checkbox"/> Internal <input type="checkbox"/> Jaw <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder <input type="checkbox"/> Toe <input type="checkbox"/> Tooth <input type="checkbox"/> Thigh <input type="checkbox"/> Torso <input type="checkbox"/> Wrist</p> <p>Location</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Front <input type="checkbox"/> Right <input type="checkbox"/> Mid <input type="checkbox"/> Side <input type="checkbox"/> Lower <input type="checkbox"/> Back</p> <p>Primary Injury 1</p> <p><input type="checkbox"/> Abrasion <input type="checkbox"/> Cold Injury <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Heat Illness <input type="checkbox"/> Laceration <input type="checkbox"/> Ligament <input type="checkbox"/> Strain Injury <input type="checkbox"/> Suspected <input type="checkbox"/> Sprain Concussion</p>	<p>Body Part Injured 2</p> <p><input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Hip <input type="checkbox"/> Internal <input type="checkbox"/> Jaw <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder <input type="checkbox"/> Toe <input type="checkbox"/> Tooth <input type="checkbox"/> Thigh <input type="checkbox"/> Torso <input type="checkbox"/> Wrist</p> <p>Location</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Front <input type="checkbox"/> Right <input type="checkbox"/> Mid <input type="checkbox"/> Side <input type="checkbox"/> Lower <input type="checkbox"/> Back</p> <p>Primary Injury 2</p> <p><input type="checkbox"/> Abrasion <input type="checkbox"/> Cold Injury <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Heat Illness <input type="checkbox"/> Laceration <input type="checkbox"/> Ligament <input type="checkbox"/> Strain Injury <input type="checkbox"/> Suspected <input type="checkbox"/> Sprain Concussion</p>	<p>Body Part Injured 3</p> <p><input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Hip <input type="checkbox"/> Internal <input type="checkbox"/> Jaw <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder <input type="checkbox"/> Toe <input type="checkbox"/> Tooth <input type="checkbox"/> Thigh <input type="checkbox"/> Torso <input type="checkbox"/> Wrist</p> <p>Location</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Front <input type="checkbox"/> Right <input type="checkbox"/> Mid <input type="checkbox"/> Side <input type="checkbox"/> Lower <input type="checkbox"/> Back</p> <p>Primary Injury 3</p> <p><input type="checkbox"/> Abrasion <input type="checkbox"/> Cold Injury <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Heat Illness <input type="checkbox"/> Laceration <input type="checkbox"/> Ligament <input type="checkbox"/> Strain Injury <input type="checkbox"/> Suspected <input type="checkbox"/> Sprain Concussion</p>	<p>Body Part Injured 4</p> <p><input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ear <input type="checkbox"/> Elbow <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Hip <input type="checkbox"/> Internal <input type="checkbox"/> Jaw <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder <input type="checkbox"/> Toe <input type="checkbox"/> Tooth <input type="checkbox"/> Thigh <input type="checkbox"/> Torso <input type="checkbox"/> Wrist</p> <p>Location</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Front <input type="checkbox"/> Right <input type="checkbox"/> Mid <input type="checkbox"/> Side <input type="checkbox"/> Lower <input type="checkbox"/> Back</p> <p>Primary Injury 4</p> <p><input type="checkbox"/> Abrasion <input type="checkbox"/> Cold Injury <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Heat Illness <input type="checkbox"/> Laceration <input type="checkbox"/> Ligament <input type="checkbox"/> Strain Injury <input type="checkbox"/> Suspected <input type="checkbox"/> Sprain Concussion</p>
<p>Disposition</p> <p><input type="checkbox"/> Air Flight <input type="checkbox"/> Continued Sport <input type="checkbox"/> EMS Transport <input type="checkbox"/> Refer to Physician <input type="checkbox"/> Refer to Hospital <input type="checkbox"/> Released to Parent <input type="checkbox"/> Released to Personal Vehicle <input type="checkbox"/> Refused Care</p>			
<p>Description of Accident</p> <hr/> <hr/>			

Signature of Trainer or Official (with no relationship to claimant) _____