

| PART A: Insured Person Information | | | | |
|--|--|----------------------------|--|--|
| Full Name: (as it appears on ID card) | Date of Birth: (mm/dd/yyyy) | Gender: | | |
| | | Male Female | | |
| ID Number: (found on ID card) | Passport/Visa Number:(attachevery page even if blank): | a complete copy, including | | |
| | | | | |
| PART B: Accident Information | | | | |
| 1. A. What sport or activity were you participating in when the accident occurred? | | | | |
| 2. Name and telephone number of any accompanying famil | y members or other witnesses | we may contact: | | |
| 3. Were you transferred from the scene of the accident to | a hospital or medical facility by | ambulance? | | |
| Yes No | | | | |
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| If No, when did you first seek medical attention? State exact date and time: | Date: | Time: |
|--|-------|-------|
| 4. Please provide complete details of your injury(ies): | | |

| PART C: Verification | | |
|---|--------------------|--|
| I verify that all information contained in this form is true, correct and complete to the best of my knowledge. | | |
| Printed Name of Insured: | Date: (mm/dd/yyyy) | |
| | | |
| Signature of Insured: | | |
| | | |
| | | |

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 fines and confinement in prison.