American Diabetes Association®

SPECIAL EVENTS
ACCIDENTAL INJURY CLAIM FORM
(Revision January 2012)

Chubb Policy # 9906-22-83

Insured's Name: AMERICAN DIABETES ASSOCIATION
1701 N. Beauregard Street
Alexandria, VA 22311

ADA Event Name/Site: _____
ADA Contact: _____
Contact Phone: _____

In the event of an incident involving personal injury/illness (trip or fall, animal bites, food poisoning, accidental needle sticks, etc.), the insurance provider must be notified immediately. This report is to be completed whenever an injury requiring medical attention occurs during an ADA sponsored event. **Within 24 hours of the injury, an Incident Report must be submitted to the parties listed below:**

SPECIAL EVENTS DEPT ONLY - fax to: 703-253-4879
ALSO fax to: The Administrative Services Manager for your market:
Dori Lockwood – fax to: 518-375-0208
Darlene Moore – fax to: 866-209-4703
Jane Wester – fax to: 866-377-3881

Date of Accident: ____/____/____ **Address where accident occurred:** _____
Time of Accident: _____ **City, State Zip** _____
Please describe in detail the circumstances of accident (attached separate sheet if needed) _____

Please describe the nature of injuries: _____

Please list the names and addresses of all treating physicians and hospitals: _____

Did police investigate the accident? Yes _____ **No** _____

Claimant's Name _____ **Age**____ **Relationship to Insured:** _____
Claimant's Address: _____ **Phone No. (H)** _____
Phone No. (W) _____
Name and Address of Employer: _____

Do you have any other Insurance? Yes _____ **No** _____ **If yes, please list all companies, type of insurance, policy numbers and insurance amounts:** _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that 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.

SIGNED (claimant or authorized person) _____ **Date** ____/____/____