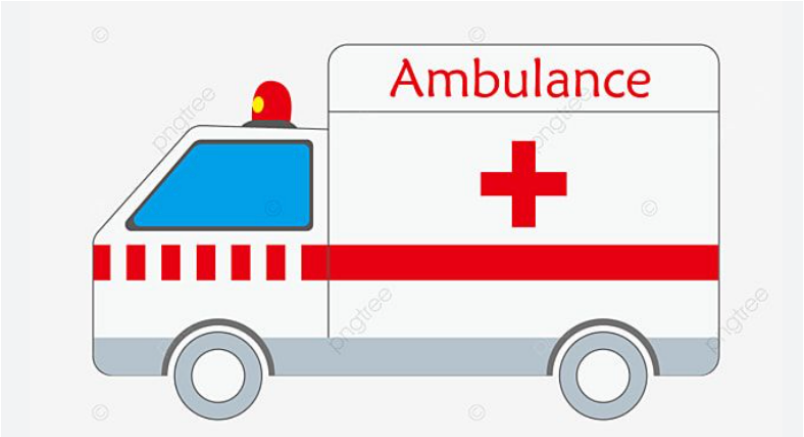
ASRDA Guidelines for a Medical Emergency & TSFSRD Safety Incident Report

Guidelines for Medical Emergency at a Dance

1. If a dancer goes down in a square, make a circle around the dancer.
2. Everyone in the square raises their hands to alert the caller.
3. Assess the situation.
4. Call 911 for assistance, if necessary.
5. Have someone stand outside to direct EMS.
6. Follow basic first aid assistance.
    a. Use ice for swelling
    b. Pressure for bleeding
    c. Make sure the person doesn't move if there is a possibility of a broken bone, etc.
7. When the situation is under control, complete the Incident Report (below) and give the insurance claim information to the person needing assistance.



TEXAS STATE FEDERATION OF SQUARE AND ROUND DANCERS®

P. O. Box 2176, Midland, TX 79702-2176

INCIDENT REPORT

Form must be completed in full and sent to the TSFSRD insurance director as soon as possible after the injury.

1. Date accident/injury occurred._____
2. Event where accident/injury occurred._____
3. Name of injured dancer
4. Nature of injury
5. Describe how the injury occurred.
6. Contact info (phone, address, etc) of the injured person.

   Phone:
   Address:

Please send the information within a few days after the incident so we will have the record on file if anything further must be addressed.

Please send to:

Insurance Director: Betty Shelton, PO Box 824, Gonzales, TX 78629-0824
betty@spiritfi.com 830-857-5143
CC: TSFSRD Executive Committee

Claim Instructions For Dancers

Claim form will be requested on an "as needed " basis. They are provided to the District by the Federation Insurance Director. The District will then forward the form to the injured person. The form must be signed by a club officer before mailing.

A copy of the claim form MUST be retained by the following:
Club
District Insurance Director (Association or Council)
Federation Insurance Director Betty Shelton

Treatment MUST commence within 90 days from the date of the accident.

Part I and II must be completed on the Notification of Injury form,

Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, an insurance questionnaire will be sent to your employer to be used as verification of no dependent coverage.

Attach any itemized bills to the claim form, along with any corresponding explanation of benefits for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax I.D. Number. Balance Due bills are not acceptable.

Attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service.

Please Note: Both an itemized bill and Explanation of Benefits (if applicable) MUST be submitted for claims to be considered for accident medical expense benefits.

Mail the Notification of Injury form, along with any other applicable correspondence to Betty Shelton, Insurance Director. **(See form below)**

NATIONAL UNION FIRE
INSURANCE COMPANY
MAIL CLAIM FORM TO:
Betty Shelton, Ins. Dir.
PO Box 824
Gonzales, Texas 78629-0824
(830) 857-5143
betty@spiritfi.com

NOTIFICATION OF INJURY

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.

Reference Number
CR40052802

FOR OFFICE USE

Policy Number
SRG9492013
Coverage Code

FORM MUST BE COMPLETED IN FULL & MAILED TO OUR OFFICE WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT

PART I —ACCIDENT REPORT

1A. Name of Organization *Texas* State Federation of *Square* & Round Dancers	1B. Name of Team			
2A. Name of Claimant (Last) (First) (Middle Initial) .	2B. Social Security No.	2C. Birthdate	2D. Sex	
3. Nature of Injury (Please describe fully indicating what part of body was injured — e.g. broken arm, sprained ankle, etc.)				
4. Describe how accident occurred. (Please provide all details) MUST BE A BODILY INJURY DUE TO AN ACCIDENT.				

5A. Did Accident Occur.	Yes	No	5B. a) Date of Accident	5C. Name of Activity
a) while the claimant was supervised?	☐	☐		
b) during sponsored activity?	☐	☐		
c) during programmed hours?	☐	☐	b) Time	5D. (Check One) ☐ Member/Player ☐ Coach ☐ Manager ☐ Other
d) on activity premises?	☐	☐		
e) while traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group?	☐	☐	f) Place	5E Name and Title of Supervisor

6A. _____ 6B. _____ 6C. _____
Signature of Coach, Manager or Delegated Authority — Title — Date

*PART II — TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF **ADULT**)*

1A. Name of Father/Guardian or Claimant (if adult) ☐ None	1B. Social Security No.	1C. Address/City/State/Zip	1D. Phone Number
2A. Name of Mother/Guardian or Spouse (if adult) ☐ None	2B. Social Security No.	2C. Address/City/State/Zip	2D. Phone Number
3A. Name of Father/Guardian's or Claimants (If adult) Employer ☐ None		3B. Address/City/State/Zip of Employer	3C. Phone Number
4A. Name of Mother/Guardian's or Spouse's (if adult) Employer ☐ None		4B. Address/City/State/Zip of Employer	4C. Phone Number

5A. List all Insurance Company(ies) under which the claimant is insured ☐ None	5B. Policy Number(s)	5C.
		☐ Medicaid ☐ Individual ☐ Group ☐ Govt.
		☐ Medicaid ☐ Individual ☐ Group ☐ Govt.
		☐ Medicaid ☐ Individual ☐ Group ☐ Govt.
		☐ Medicaid ☐ Individual ☐ Group ☐ Govt.
		☐ Medicaid ☐ Individual ☐ Group ☐ Govt.

Affidavit: I verify that the above information regarding insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent/Guardian or Claimant (if adult) — Date

Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian if claimant is under 18) — Date

SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM

NJ SR

CLAIM INSTRUCTIONS

Treatment must commence within 90 days from the date of the accident.

1. In case of an accident, notify the school/organization immediately.

2. Notify **ALL** treatment facilities (physician's office, hospital, etc.) of this insurance coverage so that any invoices and/or Explanation of Benefits (EOB) can be sent directly from the medical facility to The Maksin Group.

3. Have Part I and Part II completed on the Notification of Injury form. Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

4. Attach any itemized bills to the claim form, along with any corresponding Explanation of Benefits (EOB) for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax i.d. number. Balance Due bills are not acceptable. Be sure to attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service. Please Note: Both an itemized bill and EOB (if applicable) must be submitted for claims to be considered for accident medical expense benefits.

5. Mail the Notification of Injury form, along with any other applicable correspondence to our office within 90 days from the date of the accident. Do not leave this form with the school, coach, hospital, physician, etc. Our address is **Maksin Management Corp, P.O. Box 2648, Camden, NJ 08101-2648.** If you need further assistance, feel free to contact Customer Service at **1-800-257-6250 (phone) / 1-856-486-4376 (fax).** We will be happy to assist you.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.