

Racetrack Name _____ Policy # _____

Underwritten by National Fire Insurance Co of Pittsburgh Pa

Jockey On-Track Accident Program

First Report of Accident - Claim Information Form

Please send this completed form to:

MOC Insurance
ATTN: On-Track Claims
44 Montgomery Street, Suite 1700
San Francisco, CA 94104
FAX 415-957-0577

Injury Date _____ Injury Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Injured Person <input type="checkbox"/> Jockey <input type="checkbox"/> Exercise Rider Occupational License# _____ NOTE: Exercise Persons are not covered. Do not submit this form for Exercise Persons.
Name: _____
Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F SS# _____
Address: _____ City: _____ State: _____ Zip: _____
Current Phone #: _____ Permanent Phone #: _____
Jockey Guild Member: <input type="checkbox"/> YES <input type="checkbox"/> NO Member #: _____ Years of Experience: _____
Workers Comp: <input type="checkbox"/> YES <input type="checkbox"/> NO Other Insurance: <input type="checkbox"/> YES <input type="checkbox"/> NO Company Name _____
Name of Trainer: _____ Phone #: _____
Owner: _____ Phone#: _____
Name of Race Track: _____ State: _____
Number of Horses Starting Race: _____ Length of Race: _____ Post Position: _____
Type of Race: <input type="checkbox"/> Flat <input type="checkbox"/> Steeplechase <input type="checkbox"/> Other _____
Name of Horse _____ Type _____ Age _____
Was horse on medication? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If yes, what: _____

- What part of the body was injured? _____
<input type="checkbox"/> No injury <input type="checkbox"/> Severe Cut with bleeding <input type="checkbox"/> Broken Bones <input type="checkbox"/> Concussion
<input type="checkbox"/> Less serious bruises, cuts, scratches <input type="checkbox"/> Paralysis <input type="checkbox"/> Other _____
- Condition immediately following accident: <input type="checkbox"/> Fully Conscious <input type="checkbox"/> Conscious but Groggy
<input type="checkbox"/> Fully Unconscious <input type="checkbox"/> Unconscious, but partially responsive
- Disposition: <input type="checkbox"/> On Site First Aid Only <input type="checkbox"/> Ambulance transport to _____
<input type="checkbox"/> Pursue Further Treatment <input type="checkbox"/> Other transportation to _____

Track: <input type="checkbox"/> Dirt Surface Condition: <input type="checkbox"/> Fast <input type="checkbox"/> Good <input type="checkbox"/> Sloppy <input type="checkbox"/> Slow <input type="checkbox"/> Muddy
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Turf Surface Condition: Firm Hard Yielding Soft Wet

Weather: Clear Cloudy Raining Snow Fog

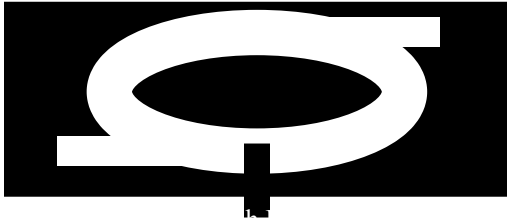
Wind: None Light 5-10 mph 10+ Steady Gusty

Location of Accident: Race Course Paddock Stable Exercise Facility
 Horse Path Other _____

Occasion: Pre-Race Activity Race Between Races Training (During Meet)
 Training (Before or After Meet)

If on Race Course, Did Accident Happen: Prior to Entering Gate Entering Gate In Gate Leaving Gate
 1st Turn 2nd Turn 3rd Turn Final Turn Chute Backstretch
 Homestretch Finishing Line Rail

Mark Location of Accident on Diagram:



How Many Horses Involved in Accident? _____

Was Injured Person: Mounting Riding Dismounting Walking Other _____

- Did Horse Fall? YES NO

- Did Horse: Break Leg Suffer Heart Attack Other _____

- Was Injured Person Thrown From Horse? YES NO

- Was Injured Person: Kicked Bitten Dragged Trampled

Was Helmet Worn? YES NO Manufacturer _____

Damaged? YES NO

Was Flack Jacket Worn? YES NO Manufacturer _____

Damaged? YES NO

Special Circumstances: Equipment Failure Intoxication Drugs Other _____

Describe How The Accident Happened:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

