



**ZURICH**<sup>®</sup>

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:

Season 2025



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<p><b>Body Part Injured 1</b></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><b>Location</b></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><b>Primary Injury 1</b></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><b>Body Part Injured 2</b></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><b>Location</b></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><b>Primary Injury 2</b></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><b>Body Part Injured 3</b></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><b>Location</b></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><b>Primary Injury 3</b></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><b>Body Part Injured 4</b></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><b>Location</b></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><b>Primary Injury 4</b></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>
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**Disposition**

<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

**Description of Accident**

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