SDSU Extension
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4-H Club Accident/Incident

Reporting Procedure

Pennington County 4-H

Pennington County 4-H recognizes that some 4-H activities carry a risk for injury to 4-H members. 4-H members work with animals, cook, play high energy games, and even train in shooting sports activities. We rely on our 4-H volunteers to help ensure that steps are taken to reduce the risk presented to our 4-H members. The safety of 4-H club members, families, and 4-H volunteers is of the utmost importance.

Accidents do happen, and when they do, there is an established procedure for managing the situation and reporting the situation.

While not required, all SDSU Extension volunteers should consider receiving certification in basic first aid.

1. Assess the situation and ensure the area around the injured 4-H member is safe.

- Remove any risks for further injury.
    - *Examples: Removing an animal from the area. Picking up a knife that may be laying on the floor.*

2. Call 911 if necessary or administer basic first aid and contact the Pennington County 4-H Office.

- If the injury is severe enough, you may need to call 911 or ask another person to call 911.
- If you are trained, administer basic first aid.
    - If the 4-H member is over 18, obtain consent from the member. If the 4-H member is under 18, obtain consent from the parent or legal guardian if they are present.
    - Consent is implied for 4-H members under 18 when parents or legal guardians are not present or if a 4-H member is unconscious.
- Contact the 4-H member's Parents or legal guardian.
    - If the parents or guardians are not reachable, contact the 4-H member's emergency contact listed in sd.4honline.com.
- All incidents severe enough to warrant a 911 call must be reported to the Pennington County 4-H Office immediately.
    - Phone: (605) 394-2188
    - After Hours: Matthew Olson – (928) 727-8989
Jane Amiotte – (605) 786-6374

Information published by:

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3. Complete a Report of Accident, Incident, Or Unsafe Condition (Non-State Automobile) form.

- All Incidents/Accidents must be reported to the Pennington County 4-H Office using the form included in this packet.
    - Employee reporting the incident: Name of the SDSU Extension 4-H Volunteer
    - Title: SDSU Extension Volunteer
    - Check “Temporary”
    - Work Phone: Best contact phone number for the SDSU Extension 4-H Volunteer
    - Sign at the bottom next to “Employee Signature” and date
    - Submit the form to the Pennington County 4-H office within 24 hours of the incident.

4. Inform the parents/guardians of the 4-H member of the American Income Life insurance policy.

- All Pennington County 4-H Members and Leaders are covered under American Income Life – Special Risk Division to provide blanket accident insurance.
    - In the event of an injury, a claim form (Page 6 and 7 of this packet) should be filed with American Income Life within thirty days of the injury/incident.
    - Note that the form must be signed by the Extension Staff, SDSU Extension Volunteer, Group Leader, or Chaperone in charge of the event or activity.
- *The American Income Life Insurance policy is covered from May 16 – May 15. Therefore this policy will be updated in May of each year.*

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REPORT OF ACCIDENT, INCIDENT, OR UNSAFE CONDITION

(NON-STATE AUTOMOBILE)

BUREAU OF ADMINISTRATION   OFFICE OF RISK MANAGEMENT

Phone (605)773-5879 Fax (605)773-5880

Department/Bureau Agency/Division	Date of Accident	Time of Accident	☐ AM ☐ PM
Type ☐ Accident ☐ Incident ☐ Unsafe Condition	Location of Accident, Incident, or Unsafe Condition		

Employee Completing Report

Name			DOB
Title	☐ Temporary ☐ Permanent	Work Phone	Home Phone

Person Involved in the Accident or Incident

Name		DOB
Address	Home Phone	Occupation
Business Address		Business Phone
What was the person involved doing at the time of the accident or incident?		

Injury

What was the nature and extent of the injury?	
Was first-aid administered? ☐ Yes ☐ No	If yes, by whom?
Describe the type of first-aid treatment given.	
Was medical treatment administered? ☐ Yes ☐ No	If yes, by whom?
Name and address of medical facility	Did accident result in fatality? ☐ Yes ☐ No

Property Damage

Owner (include address and phone)	Damage description (include estimated repair costs)

Witnesses

Name (include address and phone #)	Name (include address and phone #)

Accident Description

Legal

Law Enforcement Contacted ☐ Yes ☐ No	Name of Law Enforcement Agency

Signature *(type name in signature box if submitting electronically)*

Employee Signature:	Date:
Authorized Agency Signature:	Date:

Make copy for your records and send original to: Office of Risk Management 1429 East Sioux Pierre, SD 57501

NOTE: THIS REPORT DOES NOT CONSTITUTE A CLAIM AGAINST THE STATE OF SOUTH DAKOTA, NOR DOES IT CONSTITUTE A NOTICE OF INJURY PURSUANT TO SDCL ch. 3-21.

ATTACH ADDITIONAL SHEETS FOR MORE INFORMATION

ORM Use Only

Submitted to Claims Assoc ☐ Yes ☐ No

Date Submitted:

AMERICAN INCOME LIFE
insurance company

SPECIAL RISK
DIVISION

GROUP ACTIVITIES ACCIDENT POLICY

Policy # A SD18607 **PENNINGTON COUNTY EXTENSION ***

TABLE OF BENEFITS	Maximum Benefits
For expenses incurred within 52 weeks of the date of Accident for Medical and Surgical Treatment, X-Ray Charges, Hospital Confinement, Ambulance Expense and Prescriptions up to....	$2,500.00
For Dental Expenses incurred within 52 weeks of Accident, involving sound, natural teeth...	$ 500.00
For losses within 100 days of Accident which result in the loss of life...	$5,000.00
For losses within 100 days of Accident which cause loss of both hands or both feet, or one hand and one foot, or the total and irrecoverable loss of sight of both eyes...	$10,000.00
For losses within 100 days of Accident which cause the loss of one arm, leg foot or one hand...	$5,000.00
For losses within 100 days of Accident which cause the loss of sight of one eye...	$3,000.00

The policy provides PRIMARY, NO-DEDUCTIBLE coverage as outlined above.

This policy does not cover the following:

309. Illness
310. Eyeglass replacement of prescriptions
311. Hernia in any form
312. Suicide, self-destruction or any attempt thereat
313. Pregnancy
314. Pre-existing conditions within the last 6 mo.
315. Loss covered by Worker's Comp
316. Treatment by self, family members, or person employed by the policyholder
317. Participation in snow tubing, tobogganing, or bobsledding
318. Dental treatment other than injury to sound, natural teeth
319. Accident while under the influence of alcohol,

Certificate of Insurance

We hereby certify that application has been received and we have bound medical coverage as outlined above for all members and eligible leaders of:

PENNINGTON COUNTY EXTENSION *

Policy # A SD18607

Valid through: 5/15/19

William V[illegible]

Authorized Rep. Of AIL

AMERICAN INCOME LIFE
insurance company

SPECIAL RISK DIVISION **Claim Report Form**

How to File a Claim

1. Written notice of claim, or Claim Report Form, must be provided to the company within twenty days from the date of incident covered by this policy, but no later than ninety days from the date of incident.

- Complete the entire claim report (Parts 1-6); the claim report must be signed by a camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT.

- Valid claim reports must contain the following information:

  a. Policy number and serial number
  b. Full legal name of the injured/ill person (patient)
  c. Patient's date of birth & age
  d. Current mailing address
  e. Date of the incident (injury or illness)
  f. How injury was sustained or the nature of the illness
  g. Verification signature by Camp Director, Extension Personnel, Group Leader, or Chaperone
  h. Signature for Release of Medical Information Authorization

2. Eligible medical statements must be provided within one year from the date of treatment.
   For claim review provide:

   a. Itemized statements for services rendered by physician or hospital, including diagnosis and procedure codes.
   b. Prescription receipts complete with patient's name, Rx number, name of prescription, and price.
   c. Proof of payment along with an itemized bill if payment has been made.
      Proof of payment would be a paid receipt from provider, credit card receipt, or cancelled check.
   d. Explanation of Benefits for claims paid by personal insurance.

NOTE:

Payment is made directly to the medical provider unless otherwise indicated on the Assignment Form (Part 5).

Mail, Fax, or Email the completed Claim Report Form **directly to the company**.
DO NOT rely on medical providers to forward.

American Income Life Insurance Company
Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
Ph: 800-849-4820
Fax: 317-849-2793
Claim Department Email: ~~claims@americanincomelife.com~~
Web: www.americanincomelife.com
claimssrd@ailife.com

AMERICAN INCOME LIFE insurance company

SPECIAL RISK DIVISION

Claim Report Form

PART 1

Policy # A SD18607 Serial # NA Dates Person Was Insured May 16, 2018 - May 15, 2019

Name of Policy Holder/Group Pennington County Extension

PART 2

Name of Patient ______

Patient Date of Birth ______ Age ______ Sex M F

Patient Home Address ______

City ______ State ______ Zip ______

Patient is:

- ☐ Camper/Member
- ☐ Counselor/Instruct.
- ☐ Salaried Staff Eligible Work Comp.
- ☐ Summer Staff
- ☐ Volunteer Leader

Injury - Illness Report

PART 3

Date of Injury/Illness: ______ Time: ______ Group Activity: ______

Nature of Injury or Illness: ______ Was this condition already present before this person became insured? ☐ Yes ☐ No

Describe How and Where Injury Occurred (explain fully): *If yes, please explain*

If there was no medical treatment during insured period, was injury or illness reported to staff member? ☐ Yes ☐ No

Office Use:

Verification Signature

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - UNRELATED to patient

PART 4

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

I was the: ☐ Camp Director ☐ Extension Personnel ☐ Group Leader ☐ Other (define) ______

Name of Camp ______

Contact (**Print Name**) ______ Title: ______

Signed: ______

Day Time Phone: ______ Email ______

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Contact the Claims Department with questions.
Phone: (800) 849-4820 Email: claims@americanincomelife.com

Send completed claim forms to:
AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250
Email: ~~claims@americanincomelife.com~~ claimssrd@ailife.com
Fax: 317-849-2793

AMERICAN INCOME LIFE
insurance company

SPECIAL RISK
DIVISION

Claim Report Form

Name of Patient: ______________________ **Patient Date of Birth:** ______________

Patient Home Address ______________________

City ______________________ **State** ________ **Zip** __________

Assignment Form – Receipts must be enclosed

ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

PART 5

I hereby authorize the American Income Life Insurance Company to reimburse eligible medical benefits on the above claim to:

(Payee Name) ______________________ is to be reimbursed.

Address ______________________ City ______________________ State _____ Zip ___________

Phone #: ______________________ Email: ______________________

Date ______________________ Signed ______________________

Release of Medical Information Authorization

PART 6

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

______________________ ______________________

Signature of Patient/Guardian/ or Personal Representative Date

Contact the Claims Department with questions.
Phone: (800) 849-4820 Email: claims@americanincomelife.com

Send completed claim forms to:
AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250
Email: ~~claims@americanincomelife.com~~ claimssrd@ailife.com
Fax: 317-849-2793