National Little Britches Rodeo Association
FINAL REPORT

_____ Little Britches Rodeo
(City & State)

Rodeo Dates _____ Rodeo Classification _____

Performances _____ Slack _____

The following materials must be sent to the National Office with your final report (within **EIGHT DAYS** following the completion of the rodeo).

_____ 1. Copy of MASTER ENTRY SHEETS
_____ 2. Copy of the OFFICIAL TIMERS & JUDGES' SHEETS FOR EACH EVENT/EACH RODEO with ALL TIMES & SCORES RECORDED and ALL SHEETS SIGNED.
_____ 3. Copy of NON-MEMBER LIST, including COMPLETE ADDRESSES
_____ 4. DISQUALIFICATION FORM, if any
_____ 5. Copy of PROGRAM, if possible
_____ 6. Copy of ALL INJURY REPORTS
_____ 7. MONIES DUE NLBRA, which includes NLBRA contestant fee, non-member fee and any additional Franchise Fee
_____ 8. ASSOCIATE MEMBER VERIFICATION FORM
_____ 9. NLBRA JUDGES STOCK INSPECTION FORM
_____ 10. PRIZE LIST (required for all rodeos)
_____ 11. List of Certified Directors and Youth Certified Directors

MONIES DUE NATIONAL OFFICE

Total number of contestants for Rodeo #1 _____ x $ 9.00 fee = _____

Total number of non-members: _____ x $25.00 fee = _____

Total number of contestants for Rodeo #2 _____ x $9.00 fee = _____

Total number of non-members: _____ x $25.00 fee = _____

Franchise Fees: _____ x $75/$85/$95= _____

Is check attached? Yes _____ No _____

INJURIES – Number of injuries reported through the First Aid _____

Did you give Claim Form to all injured contestants? Yes _____ No _____

DISQUALIFICATIONS – Number of contestants disqualified: _____

Are Disqualification Forms attached? Yes _____ No _____

Signed: _____
(Rodeo Secretary)

National Little Britches Rodeo Association

5050 Edison Ave, Suite 105, Colorado Springs, CO 80915
719-389-0333 Fax 719-578-1367 1-800-763-3694
www.nlbra.com

Old West Boot Certificate Request Form

Rodeo Secretary' s Name:

Secretary's Email Address:

Franchised Rodeo Name:

Franchised Rodeo Date:

NLBRA Member's Name:

Address:

City: State: Zip:

Reason for awarding certificate:

Submit by Email

NLBRA Judge Stock Inspection Form

Stock Contractor's Name: _____

Rodeo Name: _____

Rodeo Date: _____

Pre-rodeo inspection:

1. Were all horns on the steer wrestling cattle blunted to the size of a dime? Yes ☐ No ☐
   If no, how many animals are in violation? _____

2. Are all the horned bulls used in bull riding blunted to the size of a half dollar? Yes ☐ No ☐
   If no, how many animals are in violation? _____

3. Were the calves or steers within the required weight limits? Yes ☐ No ☐
   If no, how many animals are in violation? _____

4. Were there any goat horns that exceed 4 inches that are not protected? Yes ☐ No ☐
   If yes, how many animals are in violation? _____

5. Did the stock contractor show the livestock the arena at least one hour before the start of the first performance and show all out gates? Yes ☐ No ☐

During rodeo violations:

6. Did the stock contractor use a "hot shot"? Yes ☐ No ☐
   If yes, did the stock contractor notify the contestant and the judge? Yes ☐ No ☐

7. Were there any bull tails under flank strap? Yes ☐ No ☐
   If yes, how many animals are in violation? _____

Comments: _____

_____

_____

_____

Judge's Signature _____

Judge's Printed Name _____

ASSOCIATE MEMBER VERIFICATION FORM

This form must be completed and signed by the rodeo secretary, to verify the current card #'s for all associate members working at your rodeo. Return to the National Office along with the Final Report.

NAME OF RODEO _____

CITY, STATE _____

RODEO DATE (S) _____

	ASSOCIATE MEMBER NAME	CARD #
✱	STOCK CONTRACTOR	
✱	STOCK CONTRACTOR	
✱	CLOWN/BULLFIGHTER	
✱	JUDGE	
✱	JUDGE	
✱	JUDGE	
✱	PICK-UP MAN	
✱	PICK-UP MAN	
✱	ANNOUNCER	
✱	PHOTOGRAPHER	

RODEO SECRETARY'S SIGNATURE: _____

NATIONAL LITTLE BRITCHES
RODEO ASSOCIATION
5050 Edison Ave, Suite 105, Colorado Springs, CO 80915

RODEO FRANCHISE
CANCELLATION AND DRAW-OUT POLICIES

FRANCHISE NAME: _____

RODEO DATE(S): _____

CANCELLATIONS CONTACT NAME: _____

CONTACT PHONE
NUMBER:(Required) _____
(Must be available throughout the Rodeo Weekend)

YOUR
POLICY: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REFUNDS: YES ⌜ NO ⌜

719-389-0333 FAX 719-578-1367 1-800-763-3694

WWW.NLBRA.COM

DISQUALIFICATION NOTICE

Disqualification from the NLBRA, is subject to appeal to the Executive Board for individual action, shall occur for The following:

1. *Competing under an assumed name or falsifying any entry information*
2. *Presentation of a falsified membership card or another contestant's member card.*
3. *Attempting to enter any Little Britches Rodeo while under suspension.*
4. *Competing in any unapproved rodeo employing the name Little Britches.*
5. *Evasion of financial obligation on the part of a contestant or family member incurred as a result of entry or participation in any Little Britches Rodeo.*
6. *Failure to return any prizes erroneously awarded.*

Any contestant disqualified from NLBRA competition has the right to petition the Executive Board for reinstatement. A statement from both the contestant and the party making the disqualification must be included on the petition.

For clarification of rules governing disqualification, see General Rules, Article III, Section 7, of the Rulebook.

CONTESTANT DISQUALIFIED: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
NLBRA CARD# (IF ANY): _____ DATE OF VIOLATION: _____

Disqualification was made for violation of (list rule by Article, Section and Subsection): _____
_____
EXPLANATION: _____
_____
AMOUNT DUE: _____

Was contestant notified of disqualification?	YES _____	NO _____
Was contestant notified of right to appeal?	YES _____	NO _____
Did Appeals Board hear evidence?	YES _____	NO _____
Was contestant present at Appeals Board?	YES _____	NO _____

COMMENTS: _____
_____
_____
_____

DATE: _____ SIGNATURE: _____
POSITION: _____
RODEO: _____

If this notice is because of an evasion of financial obligation, please include copies of returned checks or master entry sheet.

NON-MEMBER INSURANCE FORM

NAME OF RODEO _____

CITY, STATE _____

RODEO DATE _____

FOR INSURANCE REASONS WE MUST HAVE NON-MEMBERS FROM YOUR RODEO LISTED ON THIS SHEET AND RETURNED WITH YOUR RODEO RESULTS.

PLEASE PRINT OR TYPE AND INCLUDE FULL MAILING ADDRESS

NAME	ADDRESS

NLBRA FIRST AID / INJURY REPORT

_____ LITTLE BRITCHES RODEO

CONTESTANT NAME: _____

CONTESTANT #: _____

NAME OF PARENT OR GUARDIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF INJURY: _____ APPROXIMATE TIME OF INJURY: _____

WHERE DID INJURY OCCUR: ARENA __ TRACK __ GROUNDS __ PRACTICE __

DIVISION: SB ___ SG ___ JB ___ JG ___ LW ___ EVENT: _____

* * * * * * * * * *

GENERAL AREA

HEAD _____
NECK _____
CHEST _____
ABDOMEN _____
GROIN _____
ARM L OR R
LEG L OR R
PATIENT TO HOSPITAL

NATURE OF INJURY

_____
_____
_____
_____
_____
_____
_____

YES _____ NO _____

REMARKS: _____
_____

SIGNATURE OF FIRST AID PERSONNEL: _____

FIRST AID PERSONNEL: THIS FORM IS TO BE GIVEN TO RODEO SECRETARY.

RODEO SECRETARY: SEND THIS FORM TO THE NATIONAL OFFICE WITH YOUR FINAL REPORT.
GIVE INSURANCE CLAIM FORM TO EACH INJURED CONTESTANT.

MultiPlan

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS AND PRIMARY CARRIER EXPLANATION OF BENEFITS
3. MAIL TO *HSR*

E-mail : RODEO@HSRI.com

**** Denotes required fields***

HSR
Health Special Risk, Inc.
HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (877) 534-7669

Underwritten by Mutual of Omaha Insurance Company

Western Specialty Insurers

National Little Britches Rodeo Association

Policy Number: SR2014MO-P-052374

*** Member Number:** _____

PART I – NATIONAL LITTLE BRITCHES RODEO ASSOCIATION INSURANCE PROOF OF LOSS

*** State:** _____ *** Type of Activity - All Approved (check one):** ☐ Safety Seminar ☐ Qualifying Rodeo ☐ National Finals

1. * Claimant's First and Last Name (Injured Person)	2. * Social Security Number	3.* Gender ☐M ☐F	4. * Date of Birth	5. E-Mail
6.* Address of Injured Person	* City	* State	* Zip	7. Phone Number
8.* (If Minor) Parent's Name & Address	* City	* State	* Zip	9. Parent's Phone Number
10. *Date of Accident	11. *Date of First Treatment & Name of Physician			12. * Did Injury Result in Death? ☐YES ☐NO

13.* **Place Where Accident Occurred (Name of Town, Arena and Event You Were Participating in When Injury Occurred)**

14.* **Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc. - *specify left or right when applicable*)**

15.* **Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident**

PART II – OTHER INSURANCE STATEMENT

* Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐YES ☐NO

* If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

*SIGNATURE OF PARTICIPANT OR PARENT X	DATE

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. **(If not signed, submit proof of payment)**

SIGNATURE X _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE X _____ **DATE** _____

PART IV – RODEO SECRETARY VERIFICATION

I hereby verify that the above member participated in the _____ Rodeo or Activity on

(date)_____ during which the injury allegedly occurred.

RODEO SECRETARY SIGNATURE X _____

FRAUD STATEMENTS

General: 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, Rhode Island, West Virginia: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a 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 the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim foe each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania: 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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding **"OTHER INSURANCE STATEMENT"**, marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
   As denoted on the claim form, some information is required. Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward their itemized bills to us.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for and the specific itemized charges incurred (an itemized bill is usually in the HCFA-1500 or UB-04 format).
4. If this information is not on the bill when you send this in, we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage, you need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. ***HSR*** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (877) 534-7669. They are available from 8:00 a.m. thru 5:00 p.m. Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007

MEDICAL INFORMATION

NAME OF RODEO _____

CITY, STATE _____

RODEO DATE _____

INSTRUCTION: RODEO SECRETARY INDICATES ANY CONTESTANT WITH SPECIAL MEDIAL PROBLEMS, ALLERGIES, ECT.

CONT #	CONTESTANT NAME	MEDICAL INFORMATION