



ALLSPORT

INSURANCE MARKETING LTD.

260 Nebo Road
Hamilton, ON L8W 3K5
Phone (905) 575-1122
Fax (905) 575-4250
Toll Free 1-800-461-5087

ATHLETIC ACCIDENT CLAIM FORM

SECTION I (please print)

Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone ()	Business Phone ()	

SECTION II

Date of Accident _____, 20____ hour _____ a.m./p.m.

Location of Accident _____

What is the Injury? _____

Date of First Treatment _____

Name of Hospital taken to _____

Date of Admittance _____, 20____ hour _____ a.m./p.m.

Date of Discharge _____ Attending Physician or Dentist _____

SECTION III Describe fully how the accident happened.

SECTION IV (your sports accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses)

Name of Employer _____

What medical coverage do you have through your/spouse/parent employment? _____

Name of the Insured Employer	Name of Insurer
Address of Employer	Address
City Prov. Postal Code	Policy No. Certificate

SECTION V

I hereby certify that all the information provided above is correct.

Claimant's / Guardian Signature _____ Date _____

Send complete form along with any invoices for expenses you had to pay yourself to Pearson-Dunn Insurance & Financial Services Inc., 260 Nebo Road, Hamilton, ON L8W 3K5. Phone (905) 575-1122 Fax (905) 575-4250 Toll Free 1-800-461-5087. Please do not hesitate to call All Sport if you have any questions regarding this form. Instructions are on the reverse side. If you do not have costs at this time, please forward the form only and confirm that you intend to make a claim.

CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE

Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section.

Name of Team _____ League or Association _____

Group Policy No. _____ Type of Sport _____

Was the above player a registered member at the time of injury? Yes/No _____

Was the player injured while taking part in an authorized activity? Yes/No _____

Name _____ Position with Club _____

Telephone No. _____ Signature _____

INSTRUCTIONS

You must provide all information requested; incomplete claim forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Your Insurer must receive notice of your accident within 30 days of the accident date, and receive claim documentation within 90 days.
2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
 - patient's name
 - type of purchase or service
 - date of each purchase or service
 - amount charged for each purchase or service
3. A physician statement confirming diagnosis and recommended treatments is required if you are claiming other than dental or ambulance expense.
4. Only claims in excess of the deductible, specified in your plan details, will be considered for payment up to your maximum benefits.
5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.

• IF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:

(Please check your plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

• FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

A. PRESCRIBED DRUGS

- name of medication or drug
- date of purchase
- amount charged

B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH

- physician referral
- type of service
- date of each treatment
- amount charged for each treatment
- dates of treatments paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION

- not an eligible expense

D. AMBULANCE (Emergency to Hospital only)

- date of service
- places ambulance taken from and to
- amount charged

E. VISION CARE

- if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
- an explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY

- if your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable.
- a statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES

- a letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed, must be submitted with your receipt
- medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS

- exact date of accident
- breakdown of services performed
- circumstances surrounding the accident
- is there other dental coverage? Enclose details
- confirmation that treatments only relate to the accident
- provide other insurer's explanation
- are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN

- your Sports Accident Policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not.

YOUR SPORTS ACCIDENT POLICY MAY INCLUDE A DEDUCTIBLE AND/OR A PERCENTAGE OF REIMBURSEMENT. (Example: \$100 deductible or \$30 per treatment up to \$300 per accident.) IF IN DOUBT, CHECK YOUR PLAN DETAILS.

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

If Hospitalized, give name of hospital: _____

Date Admitted: _____ 20__ Discharged: _____ 20__

If referred to you, give name of referring physician:

Operations (or other procedures performed):

_____ Date: _____
_____ Date: _____
_____ Date: _____

Date of first consultation for above: _____ 20__

Date of first symptoms: _____ 20__ Date of Accident: _____ 20__

Has the patient ever had same or similar condition? _____

If "Yes", please state when and describe: _____

Is there any other disease or infirmity affecting the present condition?

Date: _____ 20__ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____

