Sport Accident Claim

All accidents must be reported within 30 days of incident.

To be completed by claimant

Full Name of Insured Claimant: ______________________ Date of Birth: ____________ (D / M / Y) Age: ______

Address: ______________________ (STREET ADDRESS) Phone (W): ( ) ____________

______________________ (CITY) (PROVINCE) (POSTAL CODE) Phone (H): ( ) ____________

Team Name: ______________________

League Name: ______________________

Are benefits provided under any other insurance plan? Yes ❑ No ❑

(If yes, name of Insurance Agency or Plan) ______________________

*If expenses have been submitted to another carrier please provide copy of the EOB (explanation of benefits) with attached receipts.

Date of Accident: ____________ Time of Accident: ____________ am ❑ pm ❑

Location of Accident: ______________________

How did accident occur? ______________________

Witnesses: Name ____________ Phone ____________

Describe nature of injury: ______________________

Name of Doctor: ____________ Name of Employer: ____________

Doctor's address: ____________ (STREET ADDRESS) Employer's address: ____________ (STREET ADDRESS)

____________ (CITY) (PROVINCE) ____________ (CITY) (PROVINCE)

____________ (POSTAL CODE) tel: ____________ ____________ (POSTAL CODE) tel: ____________

If hospitalized, Name and Location of Hospital: ______________________

Claimant's Signature: ______________________ Date: ____________

CLAIMANTS CERTIFICATION: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

IMPORTANT: All bills for which coverage exists under the policy must be submitted. In the event of a death claim, a certified copy of the death certificate and coroner's report must be submitted.

MEDICAL REPORT AUTHORIZATION

In connection with injuries sustained by ______________________ (Name of Claimant) as a result of an accident occurring on ____________ 20 ____ at or near ______________________ (Location).

This is your authority to provide SUTTON *SPORTSCOVER* with:

1) A report including Diagnosis, History of Treatment and Prognosis, and
2) To allow an inspection of all hospital records related to injuries received in the accident.

Claimant's signature: ______________________ Date: ____________

HAVE THE FOLLOWING SECTION COMPLETED BY ATTENDING PHYSICIAN

1) Extent of injury:

2) Description of Treatment:

3) Future treatment (if any):

Physician's signature: ______________________ Date: ____________

If there is a charge for completing this form, it is the responsibility of the patient.

Accident Incident Report Form

Please complete this form whenever a hockey accident occurs that requires medical and/or dental attention. The information you will provide will allow us to analyze the causes and types of injuries received while playing/refereeing in our category of hockey.

PLEASE CHECK ACTIVITY

Practice .... ❑
Game .... ❑
Sanctioned tournament . . ❑

PLEASE CHECK APPROPRIATE

Hit or cut by skate .... ❑
Collision with player .... ❑
Collision with goalie .... ❑
Collision with net .... ❑
Collision with boards . ❑
Skate caught in ice ... ❑
Trip .... ❑
Hit from behind ..... ❑
Hit boards after collision with player . . ❑
Jumping over player ... ❑
Hit by elbow or hand . . ❑
Hit with stick .... ❑
Hit with puck .... ❑

Penalty Called? ......Yes ❑
...............No ❑

Against you? ....Yes ❑
...............No ❑

What infraction?
Fighting .... ❑
Tripping .... ❑
Highsticking .... ❑
Cross Check .... ❑
Roughing .... ❑
Slashing .... ❑
Charging .... ❑
Other: ___________________

PLEASE CHECK EQUIPMENT WORN

Helmet / no facial protection . . ❑
Helmet / half visor .... ❑
Helmet / full facial protection . ❑
Shin pads .... ❑
Kidney pads .... ❑
Shoulder pads .... ❑
Hockey gloves .... ❑
Internal mouth guard . . ❑
Elbow pads .... ❑
Hockey pants .... ❑
Groin protection ...... ❑
External mouth guard . . ❑

PLEASE CHECK TYPE OF INJURY

Dental .... ❑
Sprain (joints) ... ❑
Laceration ...... ❑
Muscle pull .... ❑
Dislocation .... ❑
Skin (wound/puncture) ❑
Torn ligament . . ❑
Fracture ...... ❑
Bruise .... ❑
Concussion ..... ❑
Internal injuries . . ❑
Torn cartilage . . ❑

PLEASE CHECK BODY PARTS INJURED

Knee .... ❑
Ankle .... ❑
Foot .... ❑
Achilles' tendon . ❑
Lower leg ...... ❑
Thigh .... ❑
Hamstring ...... ❑
Hip .... ❑
Back .... ❑
Spine .... ❑
Chest .... ❑
Shoulder .... ❑
Collar bone .... ❑
Mid section .... ❑
Teeth .... ❑
Face .... ❑
Neck .... ❑
Chin .... ❑
Eye .... ❑
Nose .... ❑
Head .... ❑
Hand .... ❑
Fingers .... ❑
Thumb .... ❑
Wrist .... ❑
Forearm .... ❑
Elbow .... ❑
Upper arm ..... ❑

PLEASE CHECK HOCKEY ACTIVITY

Position Played:
Goalkeeper ..... ❑
Defense .... ❑
Wing .... ❑
Centre .... ❑

Accident Happened:
Face off .... ❑
Other: ____

Time of Accident:
1st period .... ❑
2nd period .... ❑
3rd period ..... ❑

Game Played:
Morning .... ❑
Afternoon ..... ❑
Evening .... ❑

HOW LONG HAS INDIVIDUAL BEEN ACTIVE IN HOCKEY?

As a Player ________ years
As a Referee ________ years
As a Coach ________ years

CLAIM FOR DENTAL EXPENSE BENEFITS

Important: Reimbursement will only be issued to the claimant.
Therefore all fees must be paid in full to the dental office and receipts submitted for reimbursement

Dentist

Name: ______________________________

Address: ______________________________

____

____

Postal Code: ______________________________

Phone: (   ) ______________________________

Patient

Name: ______________________________

Address: ______________________________

____

____

Postal Code: ______________________________

Phone: (   ) ______________________________

DATE OF SERVICE			INT TOOTH CODE	PROCEDURE CODE	TOOTH SURFACE	DENTIST FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO	YR						

This is an accurate statement of services performed and fees charged, E & OE.

TOTAL SUBMITTED FEE:

____
Signature of Dentist

Date: Day | Month | Year

For dentist's use only. For additional information re: Diagnosis, procedures, or complications and special considerations.

____

____

____

____

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

____
Signature of Patient

DENTIST

Is any of the treatment for Orthodontic purposes?

❑ Yes ❑ No

Was the treatment the result of an injury?

❑ Yes ❑ No

I hereby certify that services listed have been

❑ Performed ❑ Planned

If future treatment is planned, please indicate estimate date and cost:

____

____

____

____

____

CLAIMANT

Were these teeth whole or sound at time of accident?

❑ Yes ❑ No

Were these permanent teeth?

❑ Yes ❑ No

Are there any dental benefits or services provided under any other insurance plan?

❑ Yes ❑ No

Policy Number______________________________

Name of Insuring Agency

____

____

Describe dental injury sustained

____

____

____

____

CLAIMANT

The Claimant confirms that the following facial protection was worn at the time of injury:

- Full facial protection ❑
- Half visor ❑
- Internal mouth guard ❑
- External mouth guard ❑

By signing below, you hereby acknowledge that all of the information contained herein is true.

Name of Claimant (Please print) ______________________

Signature of Claimant ______________________

TEAM REPRESENTATIVE AND/OR LEAGUE EXECUTIVE

Name: ______________________

Address: ______________________
STREET ADDRESS

______________________ Phone (W): ( ) ______________________
CITY

______________________ ______________________ Phone (H): ( ) ______________________
PROVINCE POSTAL CODE

____
Signature of Team Representative or League Executive

By signing above, you hereby certify that this claim refers to an on-ice accident and that the information contained herein is true. Only players/referees wearing full facial protection or a half shield (visor) with either an internal or external mouth guard will be allowed to submit a dental and/or medical claim for facial injury.

MEMBER PLAYERS/REFEREES NOT WEARING THE MINIMUM PRESCRIBED FACIAL PROTECTION EQUIPMENT WILL NOT BE INSURED FOR A FACIAL AND/OR DENTAL INJURY.

FOR CARHA HOCKEY OFFICE USE ONLY

20 - ______________ 10 - ______________ 90 - ______________ Season ______________

Date Received ______________________

The collection of personal information by Canadian Adult Recreational Hockey Association (CARHA Hockey) is limited to that which is necessary for communications with you, membership registration organizing hockey tournaments as the official national body for recreational hockey in Canada, determining if our products and services, or those of our partners, meet your needs, offering and providing our products and services, or those of our partners, that may be of interest to you, collecting monies owing to CARHA Hockey or permitting CARHA Hockey to pursue available remedies or limit any damages it may sustain, complying with all applicable laws or for other purposes that are disclosed to you before or at the time the personal information is collected. Unless required by law, we will obtain your consent before using or disclosing your personal information for a purpose not previously identified.

CARHA Hockey

Suite 610, 1420 Blair Place, Ottawa, ON K1J 9L8

Tel: (613) 244-1989 / (800) 267-1854 • Fax: (613) 244-0451 / (866) 345-1975

hockey@carhahockey.ca carhahockey.ca