Return to:
CARHA
Suite 610, 1420 Blair Place
Ottawa, ON K1J 9L8
Tel: (613) 244-1989 / (800) 267-1854
Fax: (613) 244-0451 / (866) 345-1975
Angelina Fonzo: afonzo@carhahockey.ca

AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
ahclaimscan@aig.com

Reset

ACCIDENT CLAIM FORM

IMPORTANT: The form must be validated by your Association (on the Association Statement on the last page of this form). You must see a physician or dentist within 30 days of injury and submit your claim form to CARHA within 90 days of injury in order for the claim to be considered by AIG.

1. a) Full name of Insured: _____
   b) Address: _____
   c) Phone number: _____ d) Date of Birth (MM/DD/YY): _____
   e) Email: _____
   f) If the Claimant is a minor child, Name of Parent/Guardian: _____
   NOTE: If the Claimant is a minor child, the Parent/Guardian must sign this form

2. Name of the Association: _____

3. a) Date of accident (MM/DD/YY): _____ b) Place of accident: _____
   c) Circumstances: _____
   d) Injury: _____
   e) Date of first medical attention (MM/DD/YY): _____

4. a) Do you have a Group Insurance (through work, etc.) that covers paramedical expenses (Ambulance, Physiotherapy, etc.)? ☐ YES ☐ NO
   b) If yes, name of Insurance Company:
   NOTE: You must first submit your expenses through your Group Insurance and then provide us with a copy of the Explanation of benefit and a copy of your receipts

5. Name and address of Physician who treated you for this condition: _____
   _____

6. a) Did the injury require Hospitalization? ☐ YES ☐ NO
   b) If yes, hospitalization dates: from (MM/DD/YY): _____ to (MM/DD/YY): _____
   c) Name of Hospital: _____

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.
CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims 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. 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.
AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada.
AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Name of Claimant: _____
Signature of Claimant: _____ Date (MM/DD/YY): _____

PHYSICIAN'S STATEMENT

1. Name of Patient: _____
2. Diagnosis / Injury: _____

   _____
3. a) Is the condition the direct result of an accident? ☐ YES ☐ NO
   b) If yes, date of the accident (MM/DD/YY): _____
   c) Circumstances: _____

   _____
   d) Date of first attendance (MM/DDY/Y): _____
4. Recommended treatments: _____

   _____

   _____
5. a) Was the patient hospitalized: ☐ YES ☐ NO
   b) If yes, please provide name of hospital and dates:

   _____

   _____

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (please print): _____

Address: _____

Signature of Attending Physician: _____ Date (MM/DD/YY): _____

Phone Number: _____ Fax Number: _____

ASSOCIATION STATEMENT

1. Name of Injured person: _____

2. a) Name of Association: _____
   b) Name of Club / Team: _____

3. The injured person is: ☐ Member ☐ Volunteer

4. Was the person a member or volunteer at the time of the accident? ☐ YES ☐ NO

5. Did the injury occur while the person was participating in an activity approved by the Association?
   ☐ YES ☐ NO

Please attach a copy of your incident report related to this event (if available).

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

Signature: _____ Date (MM/DD/YY): _____

Title: _____ Phone Number: _____ Email: _____

The furnishing of forms shall not be an admission of liability by the Company.

Dental Claim Form only to be completed by Dentist, Dental Surgeon should your claim include a claim for dental treatment.

PART 1 DENTIST

Dentist's Name _____

Address _____

City, Province _____

Postal Code _____

Telephone _____

Patient's Last Name _____ Given Names _____

Address _____

City, Province _____

Postal Code _____

Date of Service D M Y	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00

This is an accurate statement of services performed and fees charges. E. & OE.	Total Submitted Fee
Dentist's Signature	Date: Day Month Year

FOR DENTIST'S USE ONLY.

For additional information Re: diagnosis, procedures or complications and special considerations.

FOR PLAN ADMINSTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note – Under the terms of the Policy, this report must be forwarded to CARHA Hockey within 90 days of the date of the accident. Your co-operation will be appreciated.

CLAIM APPROVED:

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.	I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.	Day Month Year Assessor
Signature of Patient (or Parent/Guardian)	Signature of Subscriber	

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage _____

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code	Treatment Indicated – use procedure code if possible	Est. Date – Treatment Day Month Year

3. Describe further potential problems and indicate time frame. _____

Date: Day Month Year

Dentist's Signature _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

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

Penalty Called? Yes ☐ No ☐

Against you? Yes ☐ No ☐

What infraction?

Fighting ☐ Roughing ☐
Tripping ☐ Slashing ☐
Highsticking ☐ Charging ☐
Cross Check ☐ Other: _____

PLEASE CHECK EQUIPMENT WORN

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

PLEASE CHECK TYPE OF INJURY

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

PLEASE CHECK BODY PARTS INJURED

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

PLEASE CHECK HOCKEY ACTIVITY

Position Played:
Goalkeeper ☐ Defense ☐ Wing ☐ Centre ☐ (e.g. Coach) ☐ Referee/Other _____

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

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PERSONAL INFORMATION NOTICE AND CONSENT

Name of Policyholder: **Policy No.:**

Date of accident (MM/DD/YY):

Place of accident:

Circumstances:

Date of first medical attention (MM/DD/YYY):

PERSONAL INFORMATION NOTICE AND CONSENT: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside Canada for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.

CERTIFICATION: I declare that to the best of my knowledge and belief, the above particulars and the statements I provide in completing this claim form and otherwise in respect of my claims are true and accurate. I understand that any misrepresentation or omission of any material fact may result in denial of the claim, coverage may be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer the full amount of any payments made to me with respect to any claims of me or my dependents if it is determined that such amounts should not have been paid in respect of such claims, and agree that the Insurer may set off any such amount against any other benefits payable to me with respect to any claims of me or my dependents by the Insurer until the Insurer has recovered such amount in full.

AUTHORIZATION: I authorize, for a period of two (2) years from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including the group policyholder) to release and exchange with, and my employer to release and disclose to, the Insurer, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as if it were the original.

Signature: Date (MM/DD/YY): Phone Number:

Address:

Email: Witness:

The furnishing of forms shall not be an admission of liability by AIG Insurance Company of Canada.

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