# ALLSPORT 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** (Note: A Physician's referral must be included with receipts for services provided by a physiotherapist, athletic therapist, chiropractor, massage therapist or osteopath). | |
|---|---|
| Date of Accident | Hour a.m. / p.m. |
| Location of Accident | |
| What is the injury? | |
| Date of First Treatment | |
| Name of Hospital taken to | |
| Date of Admittance | Hour a.m. / p.m. |
| Date of Discharge | Name of Attending Physician or Dentist |

| **SECTION III** Describe fully how the accident happened. |
|---|
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| |

| **SECTION IV** (your sport accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses) What medical coverage do you have through your/spouse/parent employment? | | | | |
|---|---|---|---|---|
| Name of Employer | | | Name of Insurer | |
| Address of Employer | | | Address of Insurer | |
| City | Prov. | Postal Code | Policy No. | Certificate Number |

**SECTION V**

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

Claimant's / Guardian's Signature Date

Send completed form, physician's referral & receipts for expenses incurred to your Provincial Sport Organization (PSO) (i.e. Basketball Manitoba, Softball Manitoba), 145 Pacific Avenue, Winnipeg, MB R3B 2Z6. (Manitoba Soccer Association address: 211 Chancellor Matheson Rd, Winnipeg, MB R3T 1Z2). It is the responsibility of the PSO after verification of membership to file the claim with Markel. If you do not have any expenses at this time, please forward the forms only. Receipts for expenses can be forwarded directly to your PSO. Any inquiries can be directed to your PSO. The PSO will then forward the claim form and any receipts to Markel @ canadaclaims@markel.com

| **Executive Director or Provincial Sport Organization** | |
|---|---|
| Name | Signature |
| Address | Phone |

**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 |
|---|---|
| Accident Policy No. | Type of Sport |
| Was the above player registered at the time of the 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 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 treatment is required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible specified in your plan 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 sport 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
     - Date of treatment 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 Sport Accident Policy does not make payment for any services or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not

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

**PART 1 DENTIST**

| Dentist's Name | Patient's Last Name | Given Names |
|---|---|---|
| Address | Address | Apt. |
| City, Province | City, Province | |
| Postal Code | Postal Code | |
| Telephone | | |

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

| 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. |
|---|---|
| Signature of Patient (or Parent/Guardian) | Signature of Subscriber |

**FOR PLAN ADMINSTRATOR USE ONLY:**

NOTICE TO DENTIST:

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

CLAIM APPROVED:

Day Month Year

Assessor

**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 | Mo. | Yr. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

3. Describe further potential problems and indicate time frame.

Date: Day Month Year

Dentist's Signature

**ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL**

# 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: _____ Discharged: _____

If referred to you, give name of referring physician:

Operations (or other procedures performed): _____

Date: _____

Date: _____

Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ Date of Accident: _____

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: _____ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____