



ALLSPORT

INSURANCE MARKETING LTD.

417 - 1367 West Broadway
Vancouver, BC V6H 4A9
Phone (604) 737-3018
Fax (604) 737-3076

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	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	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)

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

Name of 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 completed form with any expenses you had to pay yourself to:



Gymnastics Nova Scotia
5516 Spring Garden Rd, 4th Fl
Halifax, NS B3J 1G6

CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE

Do not complete this section yourself; have Gymnastics Nova Scotia 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.

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PART 1 DENTIST	
Dentist's Name _____ Address _____ City, Province _____ Postal Code _____ Telephone _____	Patient's Last Name _____ Given Names _____ Address _____ Apt. _____ City, Province _____ Postal Code _____

Date of Service			Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge
Day	Mo	Yr						
This is an accurate statement of services performed and fees charged. E. & OE.							Total Submitted Fee	
Dentist's Signature _____						Date: Day Month Year _____		

FOR PLAN ADMINISTRATOR 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

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 (or Parent/Guardian)	I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him. _____ Signature of Subscriber
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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 _____
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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: _____ 19__ Discharged: _____ 19__

If referred to you, give name of referring physician:

Operations (or other procedures performed):

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

Date of first consultation for above: _____ 19__

Date of first symptoms: _____ 19__ Date of Accident: _____ 19__

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: _____ 19__ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____