FORMS AND ALL RECEIPTS TO BE SUBMITTED TO: 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

AIG -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 - HEALTH INSURANCE INFORMATION *(THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED)*

Occupation: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed ☐ Full-Time Student

Name of Employer (If minor, list parent's employer):

1. Do you have provincial health coverage? ☐ Yes ☐ No Province: ________________________
2. Do you have other insurance? ☐ Yes ☐ No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
3. Has a claim been submitted? ☐ Yes ☐ No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLAINATIONS OF BENEFITS.)

By signing below, you hereby acknowledge that all the information contained herein is true:
Name of Claimant (Please Print): Signature of Claimant:

SECTION III

Date of Accident	Hour a.m. / p.m. (circle one)
Location of Accident:	What is the injury?
Date of First Treatment:	Name of Hospital taken to:
Date of Admittance:	Hour a.m. / p.m. (circle one)
Date of Discharge:	Name of Attending Physician or Dentist:

SECTION IV
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 the information contained herein is true:
Name of Claimant (Please Print): Signature of Claimant:

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: **CARHA Hockey**	Accident Policy No.	Type of Sport **Hockey**

Was the above player registered at the time of the injury? **Yes/No** (circle one)

Was the player injured while taking part in an authorized activity? **Yes/No** (circle one)

TEAM REPRESENTATIVE AND/OR LEAGUE EXECUTIVE

Name:	Street Address:		City:
Province:	Postal Code:	Home Phone: ( )	Work Phone: ( )

Signature of Team Representative or League Executive:

To be approved and signed by CARHA HOCKEY Rep

Name:	Position with CARHA Hockey:	Telephone No. ( )	Signature

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INSTRUCTIONS

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

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. CARHA Hockey 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

ALL FORMS AND RECEIPTS TO BE SUBMITTED TO: CARHA Hockey. If you do not have invoices at this time, please forward the form only to confirm that you intend to make a claim. Any concerns with the completion of the form can be addressed with the CARHA Hockey Claims Adjuster once your claim has been received. For assistance completing this form, please contact Angelina Fonzo; afonzo@carhahockey.ca

Lawrie INSURANCE GROUP

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 ☐ Referee/Other (e.g. Coach) ☐ ____________________

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

hockey@carhahockey.ca carhahockey.ca

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
						$ 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 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.

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.

CLAIM APPROVED:

Signature of Patient (or Parent/Guardian)

Signature of Subscriber

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: ____________________