CARHA HOCKEY

Dan Lawrie Insurance Brokers
THE NAME YOU CAN TRUST FOR INSURANCE

SPORT ACCIDENT CLAIM

ALL ACCIDENTS MUST BE REPORTED WITHIN 90 DAYS OF INCIDENT.
ALL ORIGINAL DOCUMENTATION REQUIRED BEFORE CLAIM CAN BE SUBMITTED.

To be completed by claimant

Full Name of Insured Claimant: _____ Date of Birth: _____ (D / M / Y) Age: _____

Address: _____ (STREET ADDRESS) (CITY) Phone (W): ( ) _____

_____ (PROVINCE) (POSTAL CODE) Email: _____ 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: _____

Doctor's address: _____ (STREET ADDRESS)

_____ (CITY) (PROVINCE)

_____ (POSTAL CODE) tel: _____

Name of Employer: _____

Employer's address: _____ (STREET ADDRESS)

_____ (CITY) (PROVINCE)

_____ (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 *(to be filled out by claimant)*

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 Everest Insurance Company of Canada 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 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 . . . . . ❑ 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

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 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.

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 Everest Insurance Company of Canada and CARHA Hockey, 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 Everest Insurance Company of Canada and CARHA Hockey, 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.

_____ _____

Signature of Insured or Insured's Parent/Guardian (if under age 18) Date

FORMS AND ALL ORIGINAL RECEIPTS TO BE SUBMITTED TO:

CARHA Hockey

Suite 610, 1420 Blair Place, Ottawa, ON K1J 9L8
Tel: (613) 244-1989 / (800) 267-1854

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.