ATHLETIC ACCIDENT CLAIM FORM

#101, 7382 Winston Street
Burnaby, BC V5A 2G9
Phone 604-421-9755 Ext. 2
Fax 604-421-9775
Email: info@bclacrosse.com

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. (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 III Describe fully how the accident happened.

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 along with any invoices for expenses you incurred to -
By mail:
BC Lacrosse Association
101-7382 Winston Street, Burnaby, BC V5A 2G9
By fax:
604-421-9775
By email:
info@bclacrosse.com

Please call BC Lacrosse if you have any questions regarding this form. Instructions are on the reverse side. If you do not have invoices at this time, please forward the form only to confirm that you intend to make a claim.

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. ACL6623	Type of Sport
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)	
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.

400, 200 Wellington Street West
Toronto, ON M5V 3C7
Fax 416-601-1150
Email: claims@markelintl.ca

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

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: _____