



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

MARKEL-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 EXPLANATIONS 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. **XXXXXX** 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

Please call your Insurance Broker 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.



**DAN LAWRIE
INSURANCE BROKERS**

LAWRIE INSURANCE GROUP INC.

Dan Lawrie Insurance Brokers

Contact: Tanja Link

Phone: 1-800-661-1518

Email: tlink@danlawrie.com

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

What infraction?

Fighting Roughing
Tripping Slashing
Highsticking Charging
Cross Check Other: _____

Against you? Yes
..... No

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 (e.g. Coach) Referee/Other _____

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

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			Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge
D	M	Y						

FOR PLAN ADMINISTRATOR 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.

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.

CLAIM APPROVED:

 Day Month Year Assessor

Signature of Patient (or Parent/Guardian) Signature of Subscriber

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 _____

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: _____