



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 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. _____ 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 Angela Nobles; anobles@carhahockey.ca

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. <input type="checkbox"/>	Collision with boards .. <input type="checkbox"/>	Jumping over player ... <input type="checkbox"/>
Collision with player. <input type="checkbox"/>	Skate caught in ice ... <input type="checkbox"/>	Hit by elbow or hand .. <input type="checkbox"/>
Collision with goalie. <input type="checkbox"/>	Trip <input type="checkbox"/>	Hit with stick <input type="checkbox"/>
Collision with net. <input type="checkbox"/>	Hit from behind. <input type="checkbox"/>	Hit with puck <input type="checkbox"/>
	Hit boards after collision with player ... <input type="checkbox"/>	

Penalty Called? Yes
 No

What infraction?

Fighting <input type="checkbox"/>	Roughing..... <input type="checkbox"/>
Tripping <input type="checkbox"/>	Slashing..... <input type="checkbox"/>
Highsticking <input type="checkbox"/>	Charging <input type="checkbox"/>
Cross Check <input type="checkbox"/>	Other: _____

Against you? Yes
 No

PLEASE CHECK EQUIPMENT WORN

Helmet / no facial protection. . . <input type="checkbox"/>	Kidney pads <input type="checkbox"/>	Elbow pads <input type="checkbox"/>
Helmet / half visor. <input type="checkbox"/>	Shoulder pads <input type="checkbox"/>	Hockey pants <input type="checkbox"/>
Helmet / full facial protection . . <input type="checkbox"/>	Hockey gloves <input type="checkbox"/>	Groin protection <input type="checkbox"/>
Shin pads <input type="checkbox"/>	Internal mouth guard .. <input type="checkbox"/>	External mouth guard .. <input type="checkbox"/>

PLEASE CHECK TYPE OF INJURY

Dental <input type="checkbox"/>	Muscle pull <input type="checkbox"/>	Torn ligament. . . <input type="checkbox"/>	Concussion <input type="checkbox"/>
Sprain (joints)... <input type="checkbox"/>	Dislocation. <input type="checkbox"/>	Fracture. <input type="checkbox"/>	Internal injuries . <input type="checkbox"/>
Laceration. <input type="checkbox"/>	Skin (wound/puncture) <input type="checkbox"/>	Bruise <input type="checkbox"/>	Torn cartilage .. <input type="checkbox"/>

PLEASE CHECK BODY PARTS INJURED

Knee <input type="checkbox"/>	Hip <input type="checkbox"/>	Teeth. <input type="checkbox"/>	Hand <input type="checkbox"/>
Ankle <input type="checkbox"/>	Back <input type="checkbox"/>	Face <input type="checkbox"/>	Fingers <input type="checkbox"/>
Foot <input type="checkbox"/>	Spine <input type="checkbox"/>	Neck <input type="checkbox"/>	Thumb <input type="checkbox"/>
Achilles' tendon.. <input type="checkbox"/>	Chest <input type="checkbox"/>	Chin <input type="checkbox"/>	Wrist. <input type="checkbox"/>
Lower leg <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Eye <input type="checkbox"/>	Forearm <input type="checkbox"/>
Thigh <input type="checkbox"/>	Collar bone <input type="checkbox"/>	Nose <input type="checkbox"/>	Elbow <input type="checkbox"/>
Hamstring <input type="checkbox"/>	Mid section <input type="checkbox"/>	Head <input type="checkbox"/>	Upper arm. <input type="checkbox"/>

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

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: _____