

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

## 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										
Date of Accident			Hour a.m.	/ p.m. (circle one)						
Location of Accident										
Location of Accident										
What is the injury?										
Date of First Treatme	ent	_								
Name of Hospital tak	en to									
Date of Admittance			Hour a.m.	/ p.m. (circle one)						
Date of Discharge			Name of Atte	ending Physician or Dentist						
SECTION III Des	cribe fully how the accid	dent happened.								
<b>SECTION IV</b> (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 Ins	urer						
Address of Employer			Address of I	nsurer						
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.

Do not complete this section yourse	CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE to not complete this section yourself; have your Club or eague 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 Yes/No (circle one)	Was the above player registered at the time of the injury? Yes/No (circle one)								
Was the player injured while taking Yes/No (circle one)	part in an authorized activity?								
Name	Position with Club								
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### INSTRUCTIONS

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

## IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

- Your insurer must receive notice of your accident within 30 days of the accident date and receive claim documentation within 90 days.
- 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
- A physician statement confirming diagnosis and recommended treatment is required if you are claiming other than dental or ambulance expense.
- Only claims in excess of the deductible specified in your plan will be considered for payment up to your maximum benefits.
- 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: <a href="mailto:claims@markelintl.ca">claims@markelintl.ca</a>

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Dentist's Name												Pa	tien	ťs L	.ast	Nam	е	Given Names							
Address												_	Ad	dres	SS				Apt.						
City, Province												_	City, Province												
Postal Code											-	Postal Code													
Telephone													_												
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10	For additional information Re: diagnosis, procedures or complications and special considerations.																								
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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											payable from this claim to and authorize payment						CLAIM APPROVED:								
						pany				claim															
Signature of Patient (or Parent/Guardian)  Signature of Subscriber											r							Day Month Year Assessor							
PART 2. DENTIST'S SUPPLEMENTARY REPORT  1. Description of Damage																									
2.						dicate	ed?	NO		YES 🗌	If "Ye	s" pl	ease	indic	cate:										
	Int. Tooth Code  Treatment Indicated – use procedure code if possible  Est. Date – Treatment Day Mo. Yr.														ment Yr.										
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## 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: \_\_\_\_\_ Discharged: Date Admitted: 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 Accident: Date of first symptoms: 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? (M.D.) Date: Signature Address: **Certified Specialist** Phone: