iA Financial Group

Return to:
Life and Health Claims Dept., Special Markets Solutions
400–988 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Sports Accident Claim Form

Please print in ink

Claims Procedure

Claims must be presented within 30 days from the date of injury.
Please answer all questions in full and submit completed form with itemized accounts to the address at the top of this form.
NOTE: PLEASE HAVE REVERSE OF FORM COMPLETED BY DENTIST AND/OR DOCTOR

To be Completed by Injured Person and Team Manager or Coach

Name of Team

Policy Number

Name of League or Association in Which Team Competes

Type of Athletics and Category (ie. Senior B, etc.)

Full Name of Injured Person

Initial

Phone Number

Home Address: Street

City

Province

Postal Code

Current Mailing Address : Street
(if different from above)

City

Province

Postal Code

Age

Date of Birth (D D / M M / Y Y Y Y)

Date of Accident (D D / M M / Y Y Y Y)

Time of Accident

A.M. ❑
P.M. ❑

Please provide a **detailed explanation** of how accident happened:

What injuries were received?

Was he/she injured while playing in a league game or in an officially supervised practice?

What other hospital and medical or dental insurance is carried by the injured person?

Authorization and Declaration

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.

On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to the Company any medical information, information regarding charges, or other information that the Company may need in their assessment of this claim.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Dated this _____ of _____ Year _____ Claimant: _____
DAY MONTH YEAR (4 DIGITS) *Signature*

Official Capacity (Manager, Coach, etc.): _____
(Please print)

Date Signed (D D / M M / Y Y Y Y)

Signed : _____

The Claimant is responsible for securing this form and for charges incurred for its completion.

Section A - Attending Physician's Statement

Physician Information (Print)

Name

Address

City Province Postal Code

Telephone

Patient Information (Print)

Name

Address

City Province Postal Code

Telephone

1. Diagnosis including complications (If fracture, specify bones and type of fracture)

2. Did any disease or previous injury contribute to loss?

Yes ❑ No ❑ If Yes, describe

3. To the best of my knowledge

(a) Symptoms first appeared (D D / M M M / Y Y Y Y)

(b) Patient has had same or similar condition Yes ❑ No ❑

(c) If "Yes", state when and describe

4. Date of first visit for present disability (D D / M M M / Y Y Y Y)

Date of latest attendance (D D / M M M / Y Y Y Y)

Date of Surgery (D D / M M M / Y Y Y Y)

Treatment required

5. If referred to you give name of referring Physician

Physician's Signature

(D D / M M M / Y Y Y Y)

Section B – Attending Dentist's Statement

Dentist Information (Print)

Name

Address

City Province Postal Code

Telephone

Patient Information (Print)

Name

Address

City Province Postal Code

Telephone

Date of Service Day	Month	Year	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charged. E & OE

TOTAL SUBMITTED FEE ➔

Dentist's Signature Date DD MMM YYYY

For dentist's use only. For addtional 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 also authorize the communication of information related to the coverage of services described in this form to the named dentist.

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the dentist.

Signature of patient (or parent/guardian)

Signature of subscriber

Dentist Supplementary Report (must be completed in full)

1. Description of damage

2. Teeth injured

3. Is further treatment indicated? No ☐ Yes ☐ If "Yes" please indicate:

Int.Tooth Code		Treatment indicated – Use procedure code if possible	Est. Date - Treatment DD	MMM	YYYY

Dentist's Signature

Date

(DD/MMM/YYYY)