ATHLETIC ACCIDENT CLAIM FORM

ALLSPORT
INSURANCE MARKETING LTD.

SECTION 1 (please print)

Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
Home Phone ( )	Business Phone ( )	

SECTION II

Date of Accident , 20___ Hour am/pm

Location of Accident

What is the injury?

Date of First Treatment

Name of Hospital taken to

Date of Admittance , 20___ Hour am/pm

Date of Discharge , 20___ Attending Physician or Dentist

SECTION III Describe fully how the accident happened

SECTION IV (your sports accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses)

Name of Employer

What medical coverage do you have through your/spouse/parent employment?

Name of the Insured Employer	Name of Insurer
Address of Employer	Address
City Prov. Postal Code	Policy No. Certificate

SECTION V

I hereby certify that all the information provided above is correct.

Claimant/Guardian Signature Date

CERTIFICATION OF ASSOCIATION OR CLUB - Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section.

Name of Team	
League or Association	Type of Sport
Was above player a registered member at time of injury?	Yes/No
Was player injured while taking part in an authorized activity?	Yes/No
Name	Position with Club
Signature	Telephone

EXECUTIVE DIRECTOR OF PROVINCIAL SPORT ORGANIZATION

Send completed form along with any invoices for expenses you had to pay yourself to your Provincial Sport Organization, 200 Main Street, Winnipeg, MB R3C 4M2. It is the responsibility of the Provincial Sport Organization to file the claim with Sport Manitoba. If you do not have any expenses at this time, please forward the forms only. Receipts for expenses can be forwarded directly to Sport Manitoba. Any inquiries can be directed to Sport Manitoba at 925-5604.

Name Signature

Address: Phone

CERTIFICATION OF SPORT ELIGIBILITY – SPORT MANITOBA

Signature

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and <u>return it to your patient</u>. Patient is then to return the completed form with his/her accident claim form their Provincial Sport Organization at 200 Main St., Winnipeg, MB, R3C 4M2. Any inquiries, contact Sport Manitoba Inc., 925-5604.

PATIENT'S NAME:_____ AGE:_____

ADDRESS:_____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

_____

_____

_____

_____

If brace is required, explain the medical necessity (be specific):

_____

If hospitalized, give name of hospital: _____

Date Admitted:_____20_____ Discharged: _____20_____

If referred to you, give name of referring physician:

_____

_____

Operations (or other procedures performed:)

_____ Date:_____

_____ Date:_____

_____ Date:_____

Date of first consultation for above:_____20____

Date of first symptoms:_____20_____ Date of Accident:_____20_____

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:_____20_____
Signature:_____(M.D.)

Address:_____

Certified Specialist:_____ Phone:_____

INSTRUCTIONS FOR SUBMITTING ATHLETIC ACCIDENT CLAIM FORMS

*Please remember that this insurance coverage is the **second payer**. Expenses eligible under any other health care plan(s) must be submitted to that plan(s) first. This policy will pay only the amount of expenses that are not eligible with any other insurer.*

1. Claimant completes **Sections I to V** on claim form.
2. Club or League President, Coach or Manager must complete **Certification of Association or Club**.
3. A Physician Statement and/or Dentist Form confirming diagnosis and recommended treatments must be completed and submitted with claim form if you are claiming other than ambulance expense. (Physician Statement can only be completed by a licensed Physician, that is, not a Physiotherapist, etc.)
4. Submit claim form with Physician Statement/Dentist Form to the Provincial Sport Organization you are a member of, for the Executive Director to certify eligibility of claimant and team.
5. Executive Director submits forms to Sport Manitoba Inc. to certify eligibility of sport association. Sport Manitoba forwards all information to All Sport Insurance Marketing Ltd. (Claimant then can communicate directly with insurance company.)

IMPORTANT INFORMATION TO NOTE WHEN SUBMITTING CLAIM:

1. An Athletic Accident Claim Form **must be received by All Sport Insurance Marketing Ltd. within 90 DAYS** of the accident date. **A Physician/Dentist must have been consulted within 30 DAYS** of the accident date.
2. You must provide all information requested; incomplete claim forms will not be processed. Important - Include full address, that is, **city** and **postal code**. Do not leave any questions blank or form will be considered incomplete and returned.
3. Itemized statements and paid receipts **(originals are required if there is no other coverage available)** should indicate the patient's name, name of medication prescribed, type of purchase or service, date of each purchase or service, and amount charged for each purchase or service. Once claim is submitted, eligible expenses as a result of the injury can be claimed for up to one year after the accident date.
4. If payment should be made to anyone other than the claimant, please indicate so on the receipts/information submitted.
5. **Some benefits covered under this policy are**: physiotherapist, athletic therapist, chiropractor, massage therapist, osteopath, prescribed drugs, ambulance, vision care, dental, and medical braces. (For benefits not mentioned, please contact Sport Manitoba Inc.) Hospital room accommodation is not an eligible expense.
6. **Medical braces prescribed for rehabilitation (daily wear) purposes are "covered", but medical braces required primarily for sporting type activities are "not covered"**. Notification 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. The Physician's Statement and proof of purchase is not evidence of a prescription.
7. A Physician's referral must be included with the receipts for the services provided by a physiotherapist, athletic therapist, chiropractor, massage therapist or osteopath.
8. Vision care expenses can be claimed if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to a sport related accident. An explanation must be submitted with your receipt to claim the limited benefit.

9. This policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not.

IF YOU REQUIRE FURTHER INFORMATION OR HAVE ANY CLAIM INQUIRIES, PLEASE CONTACT SPORT at (204) 925-5604.

DENTIST FORM

Please return completed form with your accident claim to your Provincial Sport Organization, 200 Main Street, Winnipeg, MB R3C 4M2. Any inquiries, contact Sport Manitoba, 925-5604.

PART 1 – DENTIST

Dentist's Name	Patient's Last Name Given Names
Address	Address
City, Province, Postal Code	City, Province, Postal Code
Telephone	

Date of Serviced Day	Mo	Yr	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: Day Month Year

FOR DENTIST'S USE ONLY:
For additional information re: diagnosis, procedures, or complications, and special considerations.

FOR PLAN ADMINISTRATOR 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 cooperation will be appreciated.

CLAIM APPROVED:

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.

_____
Signature of Patient (or Parent/Guardian)

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

_____
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 Yr

Dentist's Signature:_____