ALLSPORT

INSURANCE MARKETING LTD.

TOLL FREE 1-800-461-5087

ATHLETIC ACCIDENT CLAIM FORM - INSTRUCTIONS

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

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Ford-Dunn Insurance Brokers 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:
   - patients= 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 treatments are required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible, specified in your plan details, 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 sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.

XIF 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.)

XFOR 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
   - dates of treatments 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 an 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
   - a 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 Sports Accident 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.

YOUR SPORTS ACCIDENT POLICY MAY INCLUDE A DEDUCTIBLE AND/OR A PERCENTAGE OF REIMBURSEMENT. (Example: $100.00 deductible or $30 per treatment up to $300 per accident.) IF IN DOUBT, CHECK WITH FORD-DUNN INSURANCE FOR DETAILS.

BASEBALL ONTARIO

ATHLETIC ACCIDENT CLAIM FORM – PHYSICIAN'S STATEMENT

Note: Please do not submit claims for medical expenses covered under a Government or other Health Plan.

Full Name of Insured: _____ **Birthdate:** _____

Address: _____

If a Minor - Name of Parent: _____ **Telephone :** _____

Date of accident: _____ _____ **Hour:** _____ **am pm**

Location of accident: _____

Nature of injury: _____

If taken to hospital, name of hospital: _____

Date of admittance: _____ _____ **Hour:** _____ **am pm**

Date of discharge: _____ _____ **Hour:** _____ **am pm**

Attending Physician or Dentist's name: _____

Address: _____ **1st treatment date:** _____

Describe fully how the accident occurred: _____

Is there coverage under any other insurance or benefit plan? _____

Name of Company or Institution: _____

Address: _____

Policy No: _____ **Certificate No:** _____

Signature: _____ **Date:** _____

Certificate of Association or Club Executive

Name of Team:	**League or Association:**	**Group Policy Number:**
Was the above player a registered member at the time of injury? **Yes ☐ No ☐**	**On what date did the Insured join the team or Association?**	**Name of Sport:**
Was player injured while taking part in an authorized practice or activity? **Yes ☐ No ☐**		**An authorized League game?** **Yes ☐ No ☐**
Name: _____ **Position:** _____ **Address:** _____ **Signature:** **Telephone:**		

Please remit this form to:

Pearson-Dunn Insurance Brokers Inc.
Representative for All Sport Insurance Marketing Ltd.
260 Nebo Rd, Hamilton, ON, L8W 3K5
Tel. 905-522-6871 or 1-800-461-5087 Fax 905-575-4250

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: _____ **Date Discharged:** _____

If referred to you, give name of referring physician: _____

Operations (or other procedures) performed:

_____

_____

_____ **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? _____

_____

Signature (MD): _____ **Date:** _____

Address: _____

Certified Specialist: _____ **Telephone:** _____

DENTIST'S REPORT

DENTIST

Name: _____

Address: _____

City: _____ Province: _____

Postal Code: _____ Tel: _____

Social Insurance Number: _____

PATIENT

Name: _____

Address: _____

City: _____ Province: _____

Postal Code: _____ Tel: _____

Social Insurance Number: _____

Date of Service 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

DATE:

Dentist's Signature

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.

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

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 co-operation will be appreciated.

Date Claim Approved: _____

Assessor _____

PART 2 - DENTIST'S SUMMARY REPORT

Description of Damage:

Is further treatment indicated? Yes: ☐ No ☐ If "Yes" Please indicate:

Int. Tooth Code		Treatment Indicated - use procedure code if possible	Est. Date - Treatment Day	Mo.	Yr.

Describe further potential problems and indicate time frame:

Dentist's Signature: _____ Date: _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL