



SPORT ACCIDENT CLAIM

 $\pmb{\mathsf{A}}\mathsf{LL}$ accidents must be reported within $\pmb{90}$ days of incident. All original documentation required before claim can be submitted.

To be completed by claimant			
Full Name of Insured Claimant:		Date of Birth:	Age:
Address:)
STREET ADDRESS PROVINCE POSTAL CODE Email:	СПУ	Phone (H): ()
Team Name:			
League Name:			
Are benefits provided under any other insurance plan? Yes \(\boldsymbol{\text{\text{\text{P}}}}\) No \(\text{\tex{\tex			
(If yes, name of Insurance Agency or Plan) *If expenses have been submitted to another carrier please provide copy of t		ith attached receipts.	
Date of Accident: Time of A	Accident:	am 🗖 pm 🗖	
Location of Accident:		,	
How did accident occur?		e	Phone
Describe nature of injury:			
Name of Doctor:	Name of Employer:		
Doctor's address:street address		STREET ADDRESS	
CITY PROVINCE	CITY		PROVINCE
POSTAL CODE tel:			
If hospitalized, Name and Location of Hospital:			
Claimant's Signature:			
CLAIMANTS CERTIFICATION: The above statements are true and complete to the making of this claim, coverage can be cancelled, payment of benefits d to refund to the Insurer, the amount of any payments made in the event t	enied and past claims payments re	ecovered without refund	of any premiums paid I agre
IMPORTANT: All bills for which coverage exists under the copy of the death certificate and coroner's			leath claim, a certified
MEDICAL REPORT AUTHORI	ZATION (to be filled out	by claimant)	
In connection with injuries sustained by		(Name of Cla	imant) as a result of an
accident occurring on 20 at or r	near		(Location).
This is your authority to provide Everest Insurance Comp 1) A report including Diagnosis, History of Tr 2) To allow an inspection of all hospital reco	eatment and Prognosis, an	id ved in the accident.	
Claimant's signature:		Date:	
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HAVE THE FOLLOWING SECTION	I COMPLETED BY ATTEN	DING PHYSICIAN	
1) Extent of injury:			
2) Description of Treatment:			
3) Future treatment (if any):			
Physician's signature:		Date:	

If there is a charge for completing this form, it is the responsibility of the patient.

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.

As a Player years	As	a Referee	years	As a Coach years
HOW LONG HAS INDIVIDUAL BI	EEN ACTIVE IN HOC	KEY?		
Game Played:	Morning	🗅	Afternoon 🖵	Evening
Time of Accident:	1st period	🗅	2nd period 🖵	3rd period □
Accident Happened: Face off	Other:			
PLEASE CHECK HOCKEY ACTIVE Position Played: Goalkeeper Defe	/ITY ense □	Wing 🖵	Centre 🖵	Referee/Other (e.g. Coach)
Achilles' tendon . Lower leg	Chest	• •	Chin Eye Nose Head	Wrist
Knee	Hip	•	Teeth Face Neck	Hand
Dental	Muscle pull Dislocation Skin (wound/punct	🗖	Torn ligament	Concussion
Helmet / no facial protection	1 1 1	Kidney pads Shoulder pads Hockey gloves Internal mouth guar	🖸	Elbow pads
Penalty Called? Yes Against you? Yes No))	What infraction? Fighting Tripping Highsticking Cross Check		Roughing
PLEASE CHECK APPROPRIATE Hit or cut by skate)))	Collision with boar Skate caught in ice Trip	0	Jumping over player
PLEASE CHECK ACTIVITY Practice	1	Game	🗅	Sanctioned tournament \Box

hockey@carhahockey.ca

carhahockey.ca

CLAIM FOR DENTAL EXPENSE BENEFITS

Important: Reimbursement will only be issued to the claimant.

Therefore all fees must be paid in full to the dental office and receipts submitted for reimbursement

Dentist	Patient
Name:	Name:
Address:	Address:
Postal Code:	Postal Code:
Phone: ()	Phone: ()

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DATE OF SERVICE TOOTH CODE SURFACE FEE CHARGE CHARGES										1														
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For dentist's use only. For additional information re: Diagnosis, procedures, or complications and special considerations.																								
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Sign	nature o	of Patie	ent																					

	DEN	TIST
ls any o	of the treatment fo	or Orthodontic purposes?
Was th	e treatment the re	sult of an injury?
I hereb	y certify that servi	ces listed have been
	re treatment is plar te date and cost:	nned, please indicate
	CLAII	MANT
Were t dent?	hese teeth whole o	or sound at time of acci-
	☐ Yes	□ No
Were t	hese permanent te	eth?
	☐ Yes	□ No
	ere any dental ben any other insuranc	efits or services provided e
	☐ Yes	□ No
Policy I	Number	
	of Insuring Agency	
Describ	e dental injury sus	tained

CLAIMANT

The Claimant confirms that th	e following fac	ial protection was wo	rn at the t	ime of injury:
Full facial protection Internal mouth guard		Half visor External mout	th guard	
By signing below, you hereby acknowledge	that all of the in	nformation contained he	erein is true).
Name of Claimant (Please print)		Sig	nature of Cl	aimant
TEAM REPRESE	ENTATIVE A	ND/OR LEAGUE	EXECUT	IVE
Name:				
Address:				
STREET ADDRESS		Phone (W):	()	
CITY				
PROVINCE	POS	TAL CODE (11).	//	
Signature of Team Representative or League E	Evacutiva			
		to the amount of	of stands of	to the distance tion
By signing above, you hereby certify t contained herein is true. Only players				
internal or external mouth guard will be allow	wed to submit a	dental and/or medical cla	aim for faci	al injury.
ERSONAL INFORMATION NOTICE: I understand that the insurance Company of Canada and CARHA Hockey, its reinsure determining if coverage is in effect, investigating the applications in the provided in completing the interpretation of the event of a false or misleading statement in the making of the refund to the Insurer, the amount of any payments made in the UTHORIZATION: I authorize, for a period of not less than two der, hospital, health care institution, medical organization, clinicompensation board or similar plan or organization, benefit plan stitution or association (including obtaining information from the CARHA Hockey, or representatives thereof, all personal head cords about me in its possession that is requested while admit agree that a reproduction of this authorization shall be as validagered.	ers and authorized adrability of exclusions and information about and laim form and otherwis his claim, coverage car he event that such amount and ic and any other medical administrator, federal, he group policyholder ealth information, bene inistering my claim.	ninistrators (the "Insurer") to assed co-ordinating coverage with oth from me, and where required, co e in respect of my claims are true in be cancelled, payment of benefit ounts should not have been paid it in twenty-four months from the dat all or medically related facility, any territorial or provincial governmen or my employer) to release and e.	ss my entitleme er insurers. Fo llect information and complete to so denied and pan respect of my the hereof, any misurance comet department, oxchange with E	ent to benefits, including but not limited reference these purposes, the Insurer will also a from and exchange information with the other best of my knowledge and belief ast claims payments recovered. I agree a claim. Only including the properties of the care propany or reinsurance company, workers any other corporation or organization overest Insurance Company of Canada to the care properties of the company of Canada to the care properties of the company of Canada to the care properties of t
Signature of Insured or Insured's Parent		e 18)		Date
FORMS AND ALL O	DIGINAL RE	CEIDTS TO RE SI	UR MITTI	ED TO:
TORMO ARD ALL C.	_	Hockey	0 D W	ED IO.
Suite 610		ice, Ottawa, ON K1J 9l	Q	
		9 / (800) 267-1854	_0	
For	CARHA Hock	EY OFFICE USE ONLY		
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The collection of personal information by Canadian Adult Recreational Hockey Association (CARHA Hockey) is limited to that which is necessary for communications with you, membership registration organizing hockey tournaments as the official national body for recreational hockey in Canada, determining if our products and services, or those of our partners, meet your needs, offering and providing our products and services, or those of our partners, that may be of interest to you, collecting monies owing to CARHA Hockey or permitting CARHA Hockey to pursue available; it may sustain, complying with all applicable laws or for other purposes that are disclosed to you before or at the time the personal information is collected. Unless required by law, we will obtain your consent before using or disclosing your personal information for a purpose not previously identified.

Date Received