SPORT ACCIDENT CLAIM FORM

Full name of Insured Person (member): _____

Date of Birth (mm/dd/yyyy) _____ Male / Female: _____

Mailing Address including City and Postal Code: _____

_____

_____

Contact Person if claimant is a minor (parent or guardian): _____

Home Phone: _____

Daytime Phone Number: _____

Email address: _____

Date of Accident: _____

Location of Accident: _____

Describe in detail how the accident occurred:

_____

_____

Type of Injury: _____

Name of Doctor/Dentist: _____

Address of Doctor/Dentist: _____

Do you have other benefits provided under any other insurance plan? Yes ☐ No ☐

If yes, please provide name of Insurer and policy number(certificate):

I hereby certify that all information provided in this accident form is correct.

Claimant/Guardian signature: _____ Date: _____

Certificate of Team Manager / Association or Club Executive:

Name of Team/ League/Association: _____

Policy Number: _____

Was the player a member at the time of the accident? Yes ☐ No ☐

Was the injury during a sanctioned game or practice? _____

Name: _____ Position: _____

Signature: _____ Phone Number: _____

Date: _____

See Instruction Page for further details on submitting claims

PHYSICIAN'S STATEMENT

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician Statement

Name of Patient: _____

Date of Birth (mm/dd/yyyy) _____ Male / Female: _____

Mailing Address including City and Postal Code: _____

_____

_____

Date of first visit: _____

Complete description of the injury and your diagnosis: _____

_____

_____

_____

If hospital was required, give name of facility: _____

Date Admitted: _____ Discharge Date: _____

Name of referring physician, if any: _____

Physician Name: _____

Signature: _____

Address: _____

_____

Date: _____