Accidental Injury
The Canadian Ball Hockey Association

HOW TO FILE A CLAIM

1. **Claimant to complete, sign and date Claimant Statement section on page 1 of the attached claim form.**

2. **Claimant to get Attending Physician or Dentist to complete Physician Statement section on page 2 of the attached claim form.**

3. **Once the above is completed Claimant is to submit to the league.**

4. **League is to verify the accident and ensure the Claimant Statement and Physician Statement is completed and complete the League Statement section and submit to your Provincial Association.**

5. **Provincial Association is to review the claim and once approved submit to Canadian Ball Hockey Association.**

6. **Attach the following documents (as applicable):**

   - **Copies of Game Sheets, Game Reports, or any Referee Reports**
   - **Copies of all police reports (if applicable)**
   - **Copies of any additional documents that support your claim**

7. **Email a copy of the completed and signed and dated Accidental Injury Claim Form and all required documents to admin@cbha.com within 30 days of the accidental injury.**

8. **Retain a copy for your records.**

YOU WILL BE CONTACTED BY A CLAIMS ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED AND TO PROVIDE INFORMATION WHERE TO SUBMIT RECEIPTS FOR THE CLAIM

Return to:
Canadian Ball Hockey Association
PO Box 22005
Kingston, ON K7M 7E0
Tel: 613-815-9610 1-877-948-6662
admin@CBHA.com I www.CBHA.com

AIG Insurance Company Of Canada
145 Wellington Street West
Toronto, ON M5J 1H8
ahclaimscan@aig.com

ACCIDENT CLAIM FORM – Group Policy No.: SRG 9126066 CBHA

IMPORTANT: This claim form must be **validated** by your League, Provincial Association and National Association. Once the claimant has completed the Claimant Statement and had the Physician Statement completed by the Attending Doctor or Dentist. Please submit to your League to complete the League Statement. Once the League Statement is completed they are to submit to the Provincial Association for approval. Once the Provincial Association approval is completed they are to submit to the Canadian Ball Hockey Association for approval within 30 days following the date of the accident.

CLAIMANT STATEMENT

Insured's Surname: _____ Insured's Given Name: _____

Address: _____ Telephone No. (daytime): _____

City/Town: _____ Province: _____ Postal Code: _____

Date of Birth (M/D/Y): _____ Sex: Male ☐ Female ☐ Email: _____

1. Date of Accident (M/D/Y): _____ Date of Initial Medical attention (M/D/Y): _____
2. Location and full details of accident and nature of injury sustained: _____
3. Name of Company who carries your Group Hospital or Medical Insurance: _____
4. Name and address of Family Physician: _____
5. Name and contact information of witness to this accident: _____
6. Name and address of Surgeons or Specialists who provided treatment regarding this accident:

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government depart ofment, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada.

AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Name of insured's Parent/Guardian (if under age 18 – print please): _____

Signature of Insured or Insured's Parent/Guardian (if under age 18): _____

Date (M/D/Y): _____

PHYSICIAN'S STATEMENT

Name of Patient: _____

Full description of injury sustained: _____

_____

Date of First Attendance (M/D/Y): _____ Date of Actual Loss (M/D/Y): _____

Is loss permanent and irrecoverable? Give degree of loss: _____

_____

Is condition direct result of an accident? ☐ Yes ☐ No

Did any disease or previous injury contribute to loss? ☐ Yes ☐ No If yes, describe: _____

_____

Was Patient hospitalized? ☐ Yes ☐ No If yes, give Hospital Name and Address: _____

_____

Names and Addresses of other Physicians or Surgeons, if any, who attended Patient:

_____

_____

Are you related to or in a business relationship with this patient? ☐ Yes ☐ No

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (please print) : _____ .

Address: _____

Signature of Attending Physician: _____ Date (M/D/Y): _____

Phone Number: _____ Fax Number: _____

LEAGUE STATEMENT

Name of Claimant _____ Name of Team: _____

The Claimant is a: ☐ Member ☐ Volunteer

Was the claimant a member or volunteer on the date of the accident? ☐ Yes ☐ No

Did the injury occur while Insured was participating in an activity recognized by the Association? ☐ Yes ☐ No

Please attach a copy of your incident report related to this event.

Print Name: _____ Date (M/D/Y): _____ Signature: _____

Title: _____ Phone Number: _____ Email: _____

PROVINCIAL ASSOCIATION APPROVAL

Print Name: _____ Date (M/D/Y): _____ Signature: _____

Title: _____ Phone Number: _____ Email: _____

CANADIAN BALL HOCKEY ASSOCIATION APPROVAL

Print Name: _____ Date (M/D/Y): _____ Signature: _____

Title: _____ Phone Number: _____ Email: _____

The furnishing of forms shall not be an admission of liability by the Company.