PARTICIPANT ACCIDENT CLAIMS 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) _____

HomePhone#_____ **DaytimePhone#**_____

CellPhone # _____

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? _____

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? _____

Was the injury during a sanctioned game or practice? _____

Name _____Position _____

Signature _____Phone number _____

Date _____

See Instruction Page for further details on submitting claims

Please Return Completed Form to Your Sport Association for Signature

PHYSICIAN'S STATEMENT

Please complete this form and return to patient. **Patient's accident claim cannot be processed without the completed Physician and/or Dentist 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 _____

Please Return Completed Forms to Your Sport Association for Signature