Sport Manitoba Partner Insurance Program

The Sport Manitoba Insurance Program offers the following types of Insurance for recognized sport partner organizations.

Please note that all coverage is subject to the terms and conditions of the policy.

The information provided in this document is from the 2023/2024 renewal year and is subject to change based on policy changes implemented by the insurer for 2024/2025. Any changes will be communicated to participating sport partner organizations as it is received from the broker.

1. COMMERCIAL GENERAL LIABILITY INSURANCE

Who is insured? All members of your organization, including executives, managers, coaches, trainers, officials, employees, and volunteers while acting within the scope of their duties on your behalf.

Activities covered? Sanctioned or authorized events within your sport discipline, including related training authorized by the policy holder.
The main areas of coverage under this policy include:

There is also a possibility that your organization or group has different limits contingent on your sport discipline. For example, the commercial general liability limit you hold/have may be lower than the summary of limits and coverages below. The limit of commercial general liability is $5,000,000 for each association and for bodily injury and property damage. However, your association may have a commercial general liability limit less than $5,000,000.

1A) Commercial General Liability

The policy will pay those sums that the insured becomes legally obligated to pay as compensatory damages because of bodily injury to or damage to property of others, such as spectators, passersby, property owners and others resulting from your operations or actions.

All participating sport partner organizations are listed in one policy “Sport Manitoba Groups”.

Current limits of coverage:

- **Bodily Injury and Property Damage** - $5,000,000 Each Occurrence
  - $1000 Deductible
- **Errors and Omissions Insurance** - $5,000,000
  - $1000 Deductible
- **Product and Completed Operations** - $5,000,000 Annual Aggregate

    - $1000 Deductible
- **Personal and Advertising Injury -** $5,000,000 Any One Person or Business Entity / Annual Aggregate
    - $1000 Deductible
- **Medical Expense Limit -** $10,000 Any One Person
    - $1000 Deductible
- **Tenants' Legal Liability** - $250,000 Any One Premises
    - $1000 Deductible
- **Employer's Liability Coverage Extension** - $5,000,000 Each Claim
    - $1000 Deductible
- **Standard Non-Owned Automobile Liability Policy -** $5,000,000 Each Accident
    - $1000 Deductible
- **Injury To Participant Coverage -** $5,000,000 Each Occurrence / Annual Aggregate
    - $1000 Deductible
- **Legal Defense Expense -** $50,000 per claim / Annual Aggregate
    - $1000 Deductible
- **Abuse Coverage (Per Association)**
    - $2,0000,000 – Settled on Claims Made Basis
    - $5000 Deductible

1B) Sports Errors & Omissions Liability Insurance (E&O)

Alternative Coverage Names/Aliases: Professional liability for sports clubs, errors and omissions (E&O)

Directors and officers may be sued for actual or alleged errors or omissions while performing their duties as officials of the organization. E&O insurance will pay those sums the organization, directors and officers become legally obligated to pay as ***compensatory damages*** because of a wrongful act. Compensatory damages means claims seeking monetary compensation. The policy wording is very limited which means you can be held responsible for the defense costs. This coverage does not include employment practices, such as wrongful termination or harassment.

It is important to note that this is not a Directors & Officers Liability Policy (see next section for further details). Any "inclusive coverage" through a master policy or an organization's policy has limited coverage and may not be broad enough to cover the directors and officers' liabilities. Most "inclusive" directors and officers coverages only indemnify directors and officers for compensatory damage claims.

This **Sports Errors & Omissions Liability Insurance (E&O)** coverage extends to all member clubs, local sport organizations that are members of the provincial sport organization.

Limit $5,000,000

1C) Legal Defence Insurance

This insurance is designed to cover Dispute Resolutions, where a sport organization is involved in a "Proceeding" that does not involve monetary sum being requested by a third party. For example, a complaint(s) to the Canadian Human Rights Commission or the provincial or territorial equivalent. The Legal Expense Insurance is designed to pay the legal and other expenses incurred with respect to defending this type of action. It will allow the sports to uphold their rules and regulations. The legal defence costs is normally primary or responds first before it triggers any D&O policy in place.

1D) Abuse Liability Insurance

Coverage is in effect **ONLY** if the sport organization's abuse application and abuse protocols/guidelines have been submitted and approved by the insurer.

Definition of Abuse - Abuse means any act or threat involving punishment, harassment, molestation or any other form of mental, physical or sexual abuse.

Abuse Incident Coverage Limits of Coverage (Per Association)

- Applicable to: Each Provincial Sport Organization who has abuse liability insurance.
- Abuse Limit Each Incident: $2,000,000
- Aggregate Limit per term: $2,000,000
- Deductible: $5000

Settlement type: Claims-Made (see Appendix B for definition)

1E) Virtual Training Endorsement (if requested)

Recognized provincial sport organizations are permitted to conduct online classes under the following restrictions:

- All instruction is to be carried out by a registered provincial sport organization certified coach.
- All individuals participating must be registered with the provincial body and must be recorded by the coach.
- Publicly accessible broadcast tools such Facebook Live, YouTube, etc. and pre-recorded videos are not acceptable methods of delivering online training.
- Permitted delivery tools must include the use of controlled, multi-screen video conferencing programs such as Skype or Zoom (ZOOMUS)
- All injuries are to be documented.
- Member clubs must advise the provincial body in writing before the class and include the following information:
    1. Number of online classes per week

2. Instructor’s remote location, bearing in mind facilities are closed
3. Class Content (activities to be conducted)
4. Number of Participants (ensure all participants are current registered members before the start of the session)
5. Class is limited to the number of participants that can be viewed on a single screen and no more than four (4) participants in one location while following the Provincial Physical Distancing Guidelines
6. Participants must have signed the required Waivers and Consent Forms

See Appendix A and Appendix B for policy details and commonly asked questions.

2. PARTICIPANT ACCIDENT INSURANCE “3rd Payer Insurance”

This is a 3rd payer participant accident policy. This means that the insurance will only respond or is triggered after the limits of insurance have been exhausted under your Manitoba Health Insurance plan and any extend health plan (if applicable). Participant accident insurance is NOT Emergency Travel Medical Insurance (TMI). TMI is a separate product and coverage and can be purchased separately for additional premium.

Coverage Territory: Canada ONLY
Coverage only applies to accidents or injuries occurring within Canada.

Please note: Participant accident insurance does not extend to activities outside of Canada. Should you need coverage for potential injuries or medical expenses when outside of Canada, please seek to purchase an emergency travel medical insurance policy. (See appendix D)

Who is insured? Policy provides coverage when there is bodily injury resulting directly from a single sports accident provided that athletes, officials, coaches/managers and volunteers are properly registered with the sport organization.

An **accident** is accidental bodily injury or death sustained by an Insured due to external violent, sudden, fortuitous causes beyond the Insured's control, occurring while this insurance is in force and while:-

a) participating in a practice or competition which is organized under the supervision and direction of the governing body/sports association listed in the policy declarations; or
b) being transported with other members as a group (three or more) to or from the place of such practice or competition. In the case of travel by air, the insurance provided by this policy shall only apply to travel on a multi-engined transport type aircraft operated by a licensed airline maintaining published schedules or a licensed charter airline; within the territorial limits shown on the policy declarations.

An **injury** is bodily injury suffered by an Insured caused directly by an accident as described below independent of any sickness or other cause.

The Sport Accident Insurance Policy does not include coverage for any injury that is determined to have been from the resulted over-use, progressive or pre-existing conditions.

This policy shall not pay any benefits that are available under any government health insurance plan, whether the Insured is enrolled in such a plan or not.

The Insurer will not pay any portion of an expense referred to in this policy which is payable under any insurance plan or law or under any plan or law that will pay the expense (**second** payer). With the exception of licensed ambulance services expenses, all other expenses claimed herein must be presented or deemed medically necessary by a qualified medical practitioner for the treatment or rehabilitation of the Insured.

When making a claim, there is currently no deductible for this participant accident coverage.

See Appendix C and Appendix D for policy details and commonly asked questions.

3. EQUIPMENT (PROPERTY PACKAGE POLICY)

Property owned by your association may be insured against physical damage and theft **if the property is listed in a schedule and provided to Sport Manitoba.**

The list can be amended during policy term if new equipment etc. is acquired.

The premium cost to your association is based on an estimated rate of Premium based on value of covered property. The actual premium determined once renewal rate is set and is determined by your association's equipment (property) schedule total. (SUBJECT TO ADJUSTMENT BASED ON CLAIMS EXPERIENCE AND MARKET CONDITIONS.)

This policy covers the equipment (property) of the Insured or the equipment (property) of other for which the Insured may be liable as per schedule provided.

It is agreed that the Insurer's limit of liability shall not exceed the amount of insurance for each item as stipulated within the schedule, in respect to any one loss, disaster, or casualty.

This policy insures against all risks of direct physical loss or damage to the insured property from any external cause – subject to policy exclusions listed in the policy wording.

Deductibles

- All losses $5,000
- Mobile Equipment $1,000
- Laptop $1,000

Appendix A – Commercial General Liability Explanation of Coverage

This is a brief review of the Commercial Liability Insurance coverage available to the Sport Manitoba Group Associations but is not to be construed as a legal document. The actual policy outlines in its wording the actual coverage in force. This Appendix should be used for reference purposes only. Coverages, limits, and exclusions are subject to change at any time at the discretion of the insurance company.

1) Third Party Bodily Injury and Property Damage:

Should a third party (spectator, etc.) sue a member association or member club for bodily injury or damage to their property where they allege the member association or club was negligent, the policy would respond on your behalf and defend you and pay all compensatory damages you become legally obligated to pay as a result of bodily injury, personal injury or property damage to a third party.

Deductible or Self-Insured Retention: $1000 (One-Thousand).
Your PSO and/or your clubs are responsible for paying the $1000 deductible should a claim be made – regardless of the outcome.

2) The Tenant's All Risk Legal Liability

This section provides coverage for damage to any location rented to or leased by member associations or member clubs for which the member association or a member club is legally liable.

Deductible or Self-Insured Retention: $1000 (One-Thousand).
Your PSO and/or your clubs are responsible for paying the $1000 deductible should a claim be made – regardless of the outcome.

3) Participant Coverage:

The policy includes coverage for injury to participants. This means should an athlete, referee or official be injured while involved in a game, event or practice and choose to sue the coaches, executives, member club or the member association (or all 4) due to the injuries they sustained because they felt they were negligent, the policy would respond in the same way as (1) above.

This is a major feature of the coverage provided by this policy, as this is a significant exposure each member association has. Any lawsuit, whether frivolous or not, would be very costly to anyone involved.

Deductible or Self-Insured Retention: $1000 (One-Thousand).
Your PSO and/or your clubs are responsible for paying the $1000 deductible should a claim be made – regardless of the outcome.

4) Wrongful Acts – Errors and Omissions

Should a Director or Officer of a member association or member club be sued for an alleged wrongful act, the policy would respond to a limit of $5,000,000 settled on an occurrence basis. However, for the policy to respond or be triggered, the statement of claim must seek compensatory damages (monetary sum) in a civil suit. The insurance protects the individuals, and the organizations for their responsibility to indemnify the individual for a compensatory amount. Should the suit not involve compensatory damages, there is NO coverage under this inclusive errors and omissions.

Please note that Wrongful Acts coverage does not include insufficient severance pay to a terminated employee of an organization. This is a responsibility of each organization should they choose to terminate an employee.

5) Legal Defence Expenses Coverage:

Annual Aggregate Limit: $50,000
Deductible: $1000

This insurance is designed to cover Dispute Resolutions, where a sport organization is involved in a "Proceeding" that does not involve monetary sum being requested by a third party. Examples include:

a) A coach or player takes legal action to be re-instated to a sport, after that sport has expelled them with just cause.
b) Human Rights action taken requesting females be allowed to play with males in certain sports.
c) Territorial boundaries are challenged, with a player or coach demanding to be allowed to play/coach in a certain area that is not their designated territory.

None of these above examples involves monetary compensation. It demands certain actions be taken which go against the rules and regulations of the particular sport. The Legal Expense Insurance is designed to pay the legal and other expenses incurred with respect to defending this type of action. It will allow the sports to uphold their rules and regulations without incurring the legal costs to do so. A letter from a third-party solicitor to the sport group demanding action will trigger this action.

6) Special/Social Activities:

Social events of fundraising (bingos, etc.) activities organized by the provincial association or member clubs are also part of the coverage provided that such events and/or activities are in accordance with accepted standard procedures.

Social activities or fundraising events that are unusual or out of the norm (beer gardens to raise money, inner tube rafting, etc.) are not intended to be part of this coverage. Should you want coverage for events like these, they must first be submitted to the insurance company prior to the event and well in-advance. A separate special events policy may have to be obtained for additional premium.

To avoid confusion, if there is any doubt as to whether your event falls under the latter category, please contact Sport Manitoba.

APPENDIX B – GENERAL QUESTIONS ASKED REGARDING COMMERCIAL LIABILITY INSURANCE

1) HOW IS THE NUMBER OF MEMBERS OF THE ASSOCIATION DETERMINED?

The membership count should include all athletes, officials, coaches/managers, volunteers, and anyone else associated with your sport association on a regular basis. In many cases an estimate must be given as the membership count regularly changes. This number should be a sum total of the sport association and its entire member clubs.

Many associations have "associate non-members". These would be people who take part in some of the sport association's activities but are not official members. A percentage of these people should be included in the total number count. See Associate Member Definition on the next page.

2) ARE NON-MEMBERS COVERED?

Many sport associations allow non-members who wish to "try-out" their sport to take part in sanctioned events. Should one of these non-members be injured or cause injury to someone else and the sport association and/or the non-member is sued, the liability insurance policy would respond to cover both the sport association and the non-member within Canada.

3) ARE ALL ACTIVITIES OF MEMBER CLUBS COVERED BY THE SPORT ASSOCIATION'S LIABILITY INSURANCE COVERAGE?

The member clubs of the Provincial Sport Organization are covered by the PSO's liability insurance as long as the member clubs' sport events and related training activities are sanctioned and authorized by the PSO and follow generally accepted standard procedures of the PSO. This would include fundraising and social activities.

If a member club chooses to break away from the PSO and get involved in activities that are not generally accepted standard procedures or are not sanctioned, the liability insurance would not extend to cover this type of activity. The program was set up on the understanding the member clubs followed basic guidelines set by the PSO, and all activities must be sanctioned by PSOs.

4) WHAT IS THE DEFINITION OF AGGREGATE

The limit in an insurance policy stipulating the most it will pay for all covered losses sustained during the term of the policy.

5) What is a Claims-Made Policy?

Claims-Made Policy: A claims-made policy provides coverage for claims that occur—and are reported—*within the specific time period set forth by the policy*. This means that if a policy is canceled or the premium isn't paid, any claim that comes through will not be covered—even if the incident occurred during the period when the policy was active.

Example #1
An organization has a policy on a 'claims made' basis with Insurer A, which runs from January 1, 2023 to December 31, 2023. It decides to switch to a new policy with Insurer B on a "claims made" basis, with cover beginning on January 1, 2024. An insured event occurs on November 1, 2023, but it is not reported until January 2, 2024. In this example, the organization could find itself being unable to make an insurance claim under either policy. Insurer A would not have to settle the claim because it was made after the 'claims made' policy ended. Insurer B would not have to settle the claim because the claim 'occurred' before its cover began.

Example #2
Mike, the executive director of his non-profit sport organization purchased a claims-made D&O policy for his board of directors in 2015 and continued coverage through 2017, then cancels the D&O policy in 2017. He does not purchase any extension (extended reporting/continuity coverage) on the policy's original limits. In 2018, Marvin is sued for an incident that occurred in 2016. Since the claims-made policy is no longer in effect and he did not purchase an extended reporting or continuity coverage with the old or new company he decided to move to, Marvin is the liable party—meaning he is obligated to pay for damages, as his former insurance carrier does not cover it.

6) Extended Reporting/Continuity Coverage

E*xtended reporting period* (ERP) or continuity coverage, is an additive option made available by the carrier you decide to lapse with or the new insurance company you move to. It becomes available *only after a policy has been terminated*. In effect, an "extended or continuity" endorsement extends the limits of claims-made coverage indefinitely. It will depend on the insurance company you deal with and is not 100% guaranteed. For a claims-made policy to cover claims made after the expiration date, an extended reporting period or continuity coverage can be purchased to protect the policyholder from past incidents, despite a claim being made post-policy cancellation. To avoid miscommunication, the extended reporting/continuity coverage is not 100% guaranteed and it has to be approved or offered.

Example: Jim, the executive director of his non-profit sport organization purchased a claims-made Directors and officers policy in 2015 to protect his board of directors and continued coverage through 2017, then cancels it in 2017. He then purchases the extended reporting period/continuity coverage for 2 years. In 2018, Bob is sued for an incident that occurred in 2016. Since he was continuously covered at the time of the incident and purchased extended coverage, his old insurance carrier is still liable to pay for the suit, even though the original policy is no longer in effect.

7) COVERAGE TERRITORY | IS THE COVERAGE WORLDWIDE?

The commercial general liability (CGL) extends to your group for participation in tournaments and games that occur outside of worldwide or outside of Canada. For example, if your team visits California for a tournament. This CGL does NOT mean your operations are covered in countries like the USA. Operations may include, setting up a store-front or office with a registered address in the USA and having employees in the USA.

Effective: April 1, 2024
For activities to be covered in the USA, there must be an estimated or projected number of trips reported in advance to the underwriter to account for any adjustments to the policy. Any lawsuits must be brought in a Canadian or U.S. Court.

A friendly note that CGL is not emergency travel medical insurance. It is recommended/encouraged that your group purchases emergency travel medical insurance.

8) ARE WAIVERS A GOOD IDEA?

Waivers are a very good idea and strongly recommended. However, they are not fail-safe and do not eliminate the need for liability insurance. They are very helpful in discouraging small claims against an association and help reduce the size of larger claims. A large lawsuit is still possible, though, and the waiver will not be sufficient to dismiss it and may in fact not hold up in court at all. It is recommended that waivers be safe-kept or on file for a minimum of 7 years.

9) HOW DOES THE NON-OWNED AUTOMOBILE COVERAGE COVER THE ASSOCIATION WHEN TRAVELING AS A GROUP TO AN EVENT?

Non-owned automobile covers your association when someone is driving a vehicle not owned by the association (their own, a rented van, etc.) on behalf of the association to a sanctioned event (game, practice, etc.) and is involved in accident. For example, an individual representing the association drives to the tournament to do an errand on behalf of the association and hits a pedestrian on the way. The pedestrian, looking for compensation, may sue the driver AND the association since the driver was doing an errand on behalf of the association.

It does NOT cover situations where one parent picks up another parent's child and delivers both to a designated meeting area of the association (the club).

> **Note 1**: When a team rents a van to go to a game or event it is strongly suggested the team take out $10,000,000 Third Party Liability coverage through the van rental agency or if a resident of Manitoba, Rental Vehicle coverage can be purchased from Manitoba Public Insurance (MPI). This is particularly important when going out of the province.

Note 2: No Fault Insurance instituted by the Manitoba Public Insurance Corporation changes much of the above. However, for any out of Province travel this would still apply. Please consult with an auto plan broker or agent for any advice/expertise.

10) HOW DOES THE MEDICAL PAYMENTS WORK?

This area of coverage only applies to third parties (non-association members). This is to cover situations where a third party (i.e. spectator) is injured by an activity of the association (an athlete or ball going out of bounds and striking a spectator) and the third party requires medical attention not covered by Medicare (i.e. ambulance, dental costs). This helps to eliminate the need for the third party to actually sue the association for these out of pocket costs.

The medical payments coverage is NOT there to cover the association members. This should be covered through the participant accident (PA) Insurance (if applicable).

11) ARE PROFESSIONALS (DOCTORS) ATTENDING ASSOCIATION EVENTS COVERED BY THE ASSOCIATION'S INSURANCE?

Any professional care administrated by professionals is not covered. They would normally carry their own professional malpractice insurance coverage.

12) HOW CAN I OBTAIN PROOF OF INSURANCE?

Each association will receive a Certificate of Insurance for Commercial General Liability after completion of renewal. This Certificate of Insurance may be requested as "proof of insurance" when your association or member is using a facility to hold an event, display, etc. It is suggested that reference to your association's name be highlighted. Facility owners may request that their name be added as additional insured on the Certificate of Insurance. It is the responsibility of the Sport Group to forward this request to the broker. Request must include Facility owner name (provided by facility owner), address of facility, name of club making request and dates certificate required.

13) Does the Commercial General Liability (CGL) extend or provide coverage for our Association while in the USA?

COVERAGE – In the USA for:

- Participation in tournaments. For example, your team participates in a tournament hosted by the local host team.
- Participating in games or league games. For example, your team plays in a sanctioned "friendly match" hosted by the local host team.
- Coverage only extends to your group when no more than 25% of your sanctioned activities are in the USA. If you have more than 25%, please notify SBC Insurance right away.

NO COVERAGE – In the USA (or any other country) for:

- Hosting of tournaments
- Hosting of league games

- Emergency travel medical insurance.
- Liability for Rental vehicles
  - The CGL is not a automobile insurance policy. It does not supplement or replace the need for you to purchase automobile rental car insurance.
- Participant Accident (See Appendix C)
- Property Insurance
  - If you lose any personal property or sports equipment, there is no coverage.
  - Common occurrence is losing your luggage or baggage when you're on your way to your destination. There is no lost luggage or baggage insurance through Sport Manitoba.

RECOMMENDATIONS

- It is strongly recommended that you purchase an emergency travel medical insurance policy.

ASSOCIATED NON-MEMBER DEFINITION
"Try-it" or "Day of Event"

<u>Try It</u>

Many member clubs of Provincial Sport Organizations have "try-out/try-it" periods where they allow non-members to try out their sport in hopes of attracting new members. From the perspective of the insurer, these "non-members" are given "member status" during the "try-out" period under the category of "associate non-member." Associate non-member can benefit from the CGL insurance while trying out the sport.

If your sport has people who "try-out", provide the estimated number of individuals on the April 1 renewal package to include these non-members.

<u>Day of Event (DOE)</u>

Many member clubs of Provincial Sport Organizations also have "day of event" members who may just be members for a day or two and no longer want to be or a full-time member.

How to account for your "try-it" or "day of event" non-members:

- Determine the approximate number of people who "try-out" your sport for all of your yearly activities.
- Determine the approximate number of "day of event" non-members who participate in tournaments and yearly activities.
- Report these figures to SBC Insurance

Appendix C – Participant Accident (PA) Policy

Participant Accident Insurance

The sport accident policy is a 3rd payer participant accident policy. This means that it will only respond after the limits have been exhausted under the Manitoba Health (1st payer) and any extended health plan (2nd payer if applicable) . Please note, the participant accident (3rd payer) does NOT necessarily cover any excess expenses. For example, if your extended benefits (2nd payer) pays 80% of your medical expenses and treatment, it is NOT necessarily the case that the participant accident (3rd payer) insurance will pay the remaining 20%. In other words, the participant accident insurance may NOT pay the remaining 20% of medical expenses. Each participant claim is unique and will be reviewed and assessed by the claims adjuster assigned to your claim.
Coverage for practices and games within Canada only. One plan covers all participants, managers, coaches, executives, and field officials throughout the entire season.

DEDUCTIBLE: There is currently no deductible for this participant accident insurance coverage. This is subject to review and change on a year-to-year basis.

Please note: Non-members do not have access or cannot benefit from participant accident insurance. Participant accident is for members only.

Note: See definition of "Associated Non-Member".

Below is a summary of the main coverages and limits.

SPORT MANITOBA GROUP ASSOCIATIONS – Sport Accident

Coverage Description	Limit	Deductible: $0
Fracture Indemnity Amount	$1,000	
Principle Amount	$50,000	
Aggregate Limit Payable for any one Accident	$1,000,000	
Dental Accident Reimbursement	$10,000	
Dentures, Removable Teeth, Hearing Aids, Eyeglass and Contact Lenses	$200	
Emergency Transportation - any one Insured Person	$50	
Family Transportation - any one Insured Person	$2,500	
Medical Expense Reimbursement - any one Insured Person	$15,000	
Prosthetic Appliances - any one Insured Person	$3,000	
Rehabilitation - any one Insured Person	$3,000	
Repatriation - any one Insured Person	$5,000	
Tuition Benefit - any one Insured Person	$2,000	
Weekly Income - Waiting Period 30 days	$100	

The following is a summary of some of the limits, conditions and exclusions of the participant accident insurance.

BENEFITS

I. SCHEDULE OF SPECIFIC LOSS INDEMNITY

When injury shall result in any of the following losses, the Insurer will pay for:

When injury shall result in any of the following losses, the Insurer will pay for:

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and Sight of One Eye	The Principal Sum
Loss of One Foot and Sight of One Eye	The Principal Sum
Loss of One Arm	Three-Fourths of the Principal Sum
Loss of One Leg	Three-Fourths of the Principal Sum
Loss of One Hand	Two-Thirds of the Principal Sum
Loss of One Foot	Two-Thirds of the Principal Sum
Loss of the Entire Sight of One Eye	Two-Thirds of the Principal Sum
Loss of Thumb and Index Finger	One-Third of the Principal Sum
Loss of One Thumb or One Finger	One-Thirtieth of the Principal Sum
Loss of Speech and Hearing in Both Ears	The Principal Sum
Loss of Speech	One-Half of the Principal Sum
Loss of Hearing in Both Ears	One-Half of the Principal Sum
Loss of Hearing in One Ear	One-Sixth of the Principal Sum

Quadriplegia (total paralysis of both upper and lower limbs) The Principal SumParaplegia (total paralysis of both lower limbs) Three-Fourths of the Principal SumHemiplegia (total paralysis of upper and lower limbs of one side of the body) One-Half of the Principal Sum

II SCHEDULE OF SPECIFIC FRACTURE, DISLOCATION, TENDON SEVERANCE AND MISCELLANEOUS INDEMNITY

When injury results in any of the following fractures, dislocations, severances or miscellaneous conditions within three hundred andsixty-five (365) days after the date of the accident;

A) The Insurer will pay for the complete fracture (including Greenstick, Buckle, or Torus type fracture):

Of the skull (depressed)	100% of the Fracture Indemnity Sum
Of the skull (not depressed)	33% of the Fracture Indemnity Sum
Of the spine (one or more vertebrae)	50% of the Fracture Indemnity Sum
Of the jawbone (mandible or maxilla)	33% of the Fracture Indemnity Sum
Of the thigh (femur)	33% of the Fracture Indemnity Sum
Of the pelvis	33% of the Fracture Indemnity Sum
Of the knee cap	27% of the Fracture Indemnity Sum
Of the lower leg	25% of the Fracture Indemnity Sum

Of the shoulder blade 25% of the Fracture Indemnity Sum
Of the ankle (small bones) 25% of the Fracture Indemnity Sum
Of the wrist (small bones) 25% of the Fracture Indemnity Sum

Of the forearm (compound or comminuted) 23% of the Fracture Indemnity Sum
Of the forearm (not compound or comminuted) 12% of the Fracture Indemnity Sum
Of the sacrum or coccyx 17% of the Fracture Indemnity Sum
Of the sternum 17% of the Fracture Indemnity Sum
Of the arm, between elbow and shoulder 17% of the Fracture Indemnity Sum
Of the collarbone 12% of the Fracture Indemnity Sum
Of the nose 12% of the Fracture Indemnity Sum
Of two or more ribs 10% of the Fracture Indemnity Sum
Of one hand (one or more metacarpals) 8% of the Fracture Indemnity Sum
Of one foot (one or more metacarpals) 8% of the Fracture Indemnity Sum
Of the facial bones 8% of the Fracture Indemnity Sum
Of one rib 5% of the Fracture Indemnity Sum
Of any bone not specified above 3% of the Fracture Indemnity Sum

The Insurer will pay for the complete dislocation:
Of the hip 42% of the Fracture Indemnity Sum
Of the knee (with open primary repair) 33% of the Fracture Indemnity Sum
Of the shoulder (with open reduction) 25% of the Fracture Indemnity Sum
Of the wrist 17% of the

Fracture Indemnity Sum
Of the ankle 17% of the Fracture Indemnity Sum
Of the elbow 12% of the Fracture Indemnity Sum
Of the bones of the foot, other than toes 8% of the Fracture Indemnity Sum

B. The Insurer will pay for the severance of tendon or tendons:
Heel (Achilles) 22% of the Fracture Indemnity Sum
Ankle 20% of the Fracture Indemnity Sum
Foot (not toes) 17% of the Fracture Indemnity Sum
Elbow 17% of the Fracture Indemnity Sum
Wrist 12% of the Fracture Indemnity Sum
Hand (including fingers) 12% of the Fracture Indemnity Sum

C. The Insurer will pay in the event of:
Rupture of kidney (operative) 27% of the Fracture Indemnity Sum
Rupture of liver 27% of the Fracture Indemnity Sum
Rupture of spleen 27% of the Fracture Indemnity Sum
Puncture of lung – with open surgery 23% of the Fracture Indemnity Sum
Burns – requiring one or more skin grafts 22% of the Fracture Indemnity Sum
Knee – injured and requiring surgery (when there is no fracture or dislocation) 22% of the Fracture Indemnity SumBone operation – injured portion removed (when there is no fracture or dislocation) 20% of the Fracture Indemnity Sum

III SUPPLEMENTARY BENEFITS

If the injury shall result in a payment being made by the Insurer under the SCHEDULE OF SPECIFIC LOSS INDEMNITY or the SCHEDULE OF SPECIFIC FRACTURE, DISLOCATION, TENDON SEVERANCE AND MISCELLANEOUS INDEMNITY, the Insurer will pay in addition:

A DENTAL ACCIDENT REIMBURSEMENT

The reasonable expenses incurred within 52 weeks of a covered accident to treat, repair or rebuild teeth damaged in the coveredaccident, excluding any expenses any treatment, repair or rebuild provided solely for cosmetic or aesthetic reasons. Such expenses will be subject to limit shown on the Declarations.

B. DENTURES, REMOVEABLE TEETH, HEARING AIDS, EYEGLASS AND CONTACT LENSES

The reasonable expenses incurred within 60 days of a covered accident to replace dentures, removable teeth, hearing aids,eyeglasses or contact lenses damaged as a result of a covered accident, subject to the limit shown on Declarations.

C. EMERGENCY TRANSPORTATION

The reasonable expenses incurred for transportation, other than by a licensed ambulance service, of the Insured Person to adoctor`s office or the nearest hospital, subject to the limit shown on the Declarations.

D. FAMILY TRANSPORTATION

The reasonable expenses incurred by the immediate family for transportation by the most direct route by a licensed common carrier to attend to the Insured Person within 365 days of the date of the accident where the attending physician recommends the personal attendance by a member of the immediate family.

Such expenses will be subject to the limit shown on the Declarations.A member of the immediate family will mean the spouse, parents, grandparents, children age 18 or over, brothers, sisters of the Insured Person.

E. MEDICAL EXPENSE REIMBURSEMENT

The reasonable medical expenses incurred by an Insured Person as a result of a covered accident within 52 weeks of the date of the accident for:

(i) Licensed physiotherapist, athletic therapist, chiropractor, osteopath, registered nurse services, or other similar services approved by the Insurer in writing, and not covered under any federal, provincial government or private health care plan.
(ii) Licensed ambulance services
(iii) Crutches, splints, orthotic devices, trusses, medical braces, rental of wheelchair, hospital bed, lifts or other medical devices recommended by the attending physician, excluding splints, orthotic devices and medial braces required primarily for sports activities.

(iv) Prescription drugs not covered by any federal, provincial government or private health care plan.
(v) Hospital services not covered by any federal, provincial government or private health care plan.
(vi) Medical services incurred outside the province of residence for injuries sustained in a covered accident that occurs outside the province where the Insured Person is normally domiciled, but in no event for any expenses incurred outside of Canada.
The maximum amount payable under this section is subject to the limit shown on the Declarations.

F. PROSTHETIC APPLIANCES

The reasonable expense actually incurred up to the limit shown on the Declarations for a hearing aid, artificial limb or eye or any other prosthetic appliance prescribed by a legally qualified physician or surgeon and required as a result of such injury within one year of the date of the accident.

G. REHABILITATION

The reasonable and necessary expenses actually incurred up to the limit shown on the Declarations for special training of the Insured Person provided
such training is required because of such injury and in order for the Insured Person to be qualified to engage in an occupation in which he would not have been engaged except for such injury;
expenses are incurred within two years from the date of the accident;
no payment will be made for room or board or other ordinary living, travelling or clothing expenses.

H. REPATRIATION

The expenses incurred for preparing the deceased for burial and shipment of the body to the residence of the deceased where the injuries covered by this policy result in loss of life of an Insured Person beyond 200 kilometres from their permanent city of residence, and within 365 days from the date of the accident, subject to the limit shown on the Declarations.

I. TUITION BENEFIT

The expenses incurred within six (6) months of the date of accident for tutorial services of a qualified teacher certified by the Provincial Ministry of Education at a rate not to exceed $25.00 per hour, as well as reasonable expenses for the rental of necessary equipment and program software are required and approved by the Board of Education in the jurisdiction in which the Insured Person is enrolled in studies. All benefits under this section are subject to an aggregate limit as shown on the Declarations.

IV WEEKLY INCOME - TOTAL DISABILITY - ACCIDENT

The Insurer hereby agrees to pay the benefit hereinafter described for loss resulting directly and independently of all other causesfrom bodily injuries sustained by an Insured Person in a covered accident, while this Policy is in force (hereinafter referred to as "such injuries") as follows:

If "such injuries" shall within sixty days from date of accident totally and continuously disable the Insured Person and prevent the Insured Person from performing any and every duty pertaining to the Insured Person's occupation or employment withthe Insured the Insurer will pay from the first day of disability following the Waiting Period of 30 days for the period of such continuous total disability but not exceeding 104 (one hundred and four) weeks, Weekly Income at the rate specified in the Declarations.

For any period of total disability involving part of a week the Insurer will pay one seventh of the Weekly Income benefit specifiedin the Schedule for each day of such part of a week.
SPECIAL EXCLUSION**:** No benefit shall be payable under this Section IV unless the Insured Person shall be attended by alegally qualified physician or surgeon.

EXCLUSIONS

The Insurer shall not be liable to pay benefit under this section in respect to bodily injuries caused directly or indirectly, solely orpartly

1. by war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrectionor military power;
2. while the Insured Person is serving in the armed forces in time of war;
3. by bodily or mental infirmity of the Insured Person or by hernia either as a cause or effect, ptomaines, bacterial infections (exceptpyogenic infections which shall occur with and through an accidental cut or wound) or by any kind of disease;
4. by suicide or attempt thereof including any intentionally self-inflicted injury;
5. by air travel, except as provided in Special Conditions 4.
6. in whole or in part, out of "terrorism" or out of any activity or decision of a government agency or other entity to prevent, respondto or terminate "terrorism". This exclusion applies regardless of any other contributing or aggravating cause or event that contributes concurrently or in any sequence to the bodily injury.

LIMITATIONS

1. If the Insured Person should sustain more than one of the losses described in Section I, II, or III above as a result of one accidentthe Insurer will pay the amount stated for each such loss up to but not exceeding in aggregate the amount referred to as the Principal Sum.
2. The maximum amount payable under this policy as a result of any one accident shall be $1,000,000 in aggregate regardless of thenumber of Insured Persons injured.
3. Except as provided under Section III – B, there is no benefit payable for purchase, repair or replacement of eyeglasses, contactlenses, or prescriptions therefor.
4. This policy will not pay for any benefits that are available under any government health insurance plan, whether the insured isenrolled in such a plan or not.
5. The Insurer will not pay any portion of an expense referred to in this policy which is payable under any insurance plan, or law orunder any plan or law that will pay the expense. With the exception of licensed ambulance expenses, all other expenses claimedherein must be presented or deemed medically necessary by a qualified medical practioner for the treatment or rehabilitation of the Insured Person.

6. In no case may an Insured Person be covered under more than one sports accident policy. Excess premium paid shall be refundedupon request.
7. This policy does not apply to and no benefits will be payable to professional athletes earning the major portion of their incomefrom sports activity.

SPECIAL CONDITIONS

1. PRINCIPAL SUM

The Principal Sum shall be the amount specified in the Declarations as the Principal Sum.

2. **The Fracture Indemnity** amount shall be the amount specified in the Declarations as the Fracture IndemnitySum

3. PERMANENT TOTAL DISABILITY

If "such injuries" shall within 365 days from the date of accident totally and continuously disable the Insured Person and prevent the Insured Person from engaging in each and every occupation or employment for compensation or profit for which the Insured Person is reasonably qualified by reason of his/her education, training or experience and at the expiration of 365 days of such total and continuous disability the Insured Person shall, in the opinion of an independent legally qualified doctor of medicine chosen jointly by the Insured

Person and the Insurer, be considered to be totally and permanently disabled and prevented from performing any occupation or employment for compensation or profit for which the Insured Person is reasonably qualified by reason of his/her education, training or experience the Insurer will pay the Principal Sum benefit, less any benefit paid or payable under The Schedule of Specific Loss Indemnity.

4. AIR TRAVEL

The Insurer will pay benefits as provided for loss resulting from "such injuries" sustained while the Insured Person is travelling as a passenger in any civil aircraft or any transport type aircraft operated by the Transport Command of the Canadian Armed Forces or its foreign equivalent, but not as a pilot, officer or other member ofthe crew or having any duties related to the flight, provided;

A in respect to aircraft, other than aircraft operated by the Transport Command of the Canadian Armed Forcesor its foreign equivalent, a certificate of airworthiness is in force at the time "such injuries" are sustained; and

B. the aircraft is not being used for aviation training or practice purposes or for experimental or test purposes.

5. EXPOSURE AND DISAPPEARANCE

If by reason of a covered accident an Insured Person is unavoidably exposed to the elements and as the result ofsuch exposure suffers a loss for which indemnity is otherwise payable hereunder, such loss will be covered under the terms of this policy.

If the Insured Person is not found within twelve months after the date of the disappearance, forced landing,stranding, sinking or wrecking of the conveyance in which the Insured Person was

riding at the time of theaccident and under such circumstances as would otherwise be covered hereunder, it will be presumed the Insured Person suffered loss of life, resulting from bodily injury caused by an accident at the time of such disappearance, forced landing, stranding, sinking or wrecking.

6. TIME INSURED

This policy provides coverage for 24 hours of each day within the Policy Period.

7. LOSS PAYABLE

The benefits are payable only to the Insured Person that has sustained the loss or to the estate of the InsuredPerson that has sustained the loss.

DEFINITIONS

1. The unqualified word "Declarations" shall mean the Declaration Page(s) applicable to this form.
2. The term "Named Insured" shall mean the Insured named on the Declaration Page.
3. The term "Insured Person" shall mean the Insured named on the Declaration Page, if an individual; all partnersof a partnership; the owner of an organization other than an individual or partners; and all executive officers, players, managers, coaches, trainers and members of officiating crews of the `Named Insured, and executive officers of member teams listed in the policy declarations.

4. The word "Loss" shall mean
   (a) as used in the Schedule of Specific Loss Indemnity,
      I. with reference to quadriplegia, paraplegia and hemiplegia, the complete and irreversible paralysis ofsuch limbs;
      II. with reference to hand or foot, the complete severance through or above the wrist or ankle joint, butbelow the elbow or knee joint;
      III. with reference to arm or leg, the complete severance through or above the elbow or knee joints;
      IV. with reference to sight of eye, the irrecoverable loss of the entire sight thereof;
      V. with reference to thumb and index finger, the complete severance through or above the first phalange;
      VI. with reference to thumb or finger, the complete severance through or above the first phalange;
      VII. with reference to hearing or speech, the total and permanent loss thereof;

   (b) complete and irreversible paralysis.

      4. Terrorism means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force committed by or on behalf of any group(s), organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section ofthe public.

STATUTORY CONDITIONS ACCIDENT AND SICKNESS INSURANCE

1. (1) THE CONTRACT

The application, the accident and sickness wording. any document attached to the accident and sickness wording when issued, and any amendment to the contract agreed upon in writing after the accident and sickness wording is issued, constitute the entire contract, and no agent has authority to change the contractor waive any of its provisions.

(2) WAIVER

The insurer shall be deemed not to have waived any condition of this contract, either in whole or in part,unless the waiver is clearly expressed in writing signed by the insurer.

(3) COPY OF APPLICATION

The insurer shall, upon request, furnish to the insured or to a claimant under the contract a copy of theapplication.

2. MATERIAL FACTS

No statement made by the insured or person insured at the time of application for this contract shall be used indefence of a claim under or to avoid this contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

3. CHANGES IN OCCUPATION

(1) If after the contract is issued the person insured engages for compensation in an occupation that is classifiedby the insurer as more hazardous than that stated in this contract, the liability under this contract is limited to the amount that the premium paid would have purchased for the more hazardous occupation according tothe limits, classification of risks and premium rates in use by the insurer at the time the person insured engaged in the more hazardous occupation.

(2) If the person insured changes his occupation from that stated in this contract to an occupation classified bythe insurer as less hazardous and the insurer is so advised in writing, the insurer shall either,

(a) reduce the premium rate, or

(b) issue a policy for the unexpired term of this contract at the lower rate of premium applicable to theless hazardous occupation,

according to the limits, classification of risks and premium rates used by the insurer at the date of receipt ofadvice of the change in occupation, and shall refund to the insured the amount by which the unearned premium on this contract exceeds the premium at the lower rate for the unexpired term.

4. RELATION OF EARNINGS TO INSURANCE

Where the benefits for loss of time payable hereunder, either alone or together with benefits for loss of time under another contract, including a contract of group accident insurance or group sickness insurance or of bothand a life insurance contract providing disability insurance, exceed the money value of the time of the person insured, the insurer is liable only for that proportion of the benefits for

loss of time stated in this policy that themoney value of the time of the person insured bears to the aggregate of the benefits for loss of time payable under all such contracts and the excess premium, if any, paid by the insured shall be returned to him by the insurer.

5. TERMINATION BY INSURED

The insured may terminate this contract at any time by giving written notice of termination to the insurer by registered mail to its head office or chief agency in the Province, or by delivery thereof to an authorized agent of the insurer in the Province, and the insurer shall upon surrender of this policy refund the amount of premiumpaid in excess of the short rate premium calculated to the date of receipt of such notice according to the table inuse by the insurer at the time of termination.

6. TERMINATION BY INSURER

(1) The insurer may terminate this contract at any time by giving written notice of termination to the insuredand by refunding concurrently with the giving of notice the amount of premium paid in excess of the prorata premium for the expired time.

(2) The notice of termination may be delivered to the insured, or it may be sent by registered mail to the latestaddress of the insured on the records of the insurer.

(3) Where the notice of termination is delivered to the insured, five days notice of termination shall be given; where it is mailed to the insured, ten days notice of termination shall be given, and the ten days shall beginon the day following the date of mailing of notice.

1. **(1) NOTICE AND PROOF OF CLAIM**

The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them,shall,

(a) give written notice of claim to the insurer,

(i) by delivery thereof, or by sending it by registered mail to the head office or chief agency of theinsurer in the Province, or

(ii) by delivery thereof to an authorized agent of the insurer in the Province, not later than thirty daysfrom the date a claim arises under the contract on account of an accident, sickness or disability;

(b) within ninety days from the date a claim arises under the contract on account of an accident, sicknessor disability, furnish to the insurer such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby, the right of the claimant to receive payment, his age, and the age of the beneficiary if relevant;and

(c) if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the accident,sickness or disability for which claim may be made under the contract and as to the duration of such disability.

(2) FAILURE TO GIVE NOTICE OR PROOF

Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the accident or the date a

claim arises underthe contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

8. INSURER TO FURNISH FORMS FOR PROOF OF CLAIM

The insurer shall furnish forms for proof of claim within fifteen days after receiving notice of claim, but wherethe claimant has not received the forms within that time he may submit his proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of theextent of the loss.

9. RIGHTS OF EXAMINATION

As a condition precedent to recovery of insurance moneys under this contract,

(a) the claimant shall afford to the insurer an opportunity to examine the person of the person insured whenand so often as it reasonably requires while the claim hereunder is pending; and

(b) in the case of death of the person insured, the insurer may require an autopsy subject to any law of theapplicable jurisdiction relating to autopsies.

10. WHEN MONEYS PAYABLE OTHER THAN FOR LOSS OF TIME

All moneys payable under this contract, other than benefits for loss of time, shall be paid by the insurer withinsixty days after it has received proof of claim.

11. WHEN LOSS OF TIME BENEFITS PAYABLE

The initial benefits for less of time shall be paid by the insurer within thirty days after it has received proof of claim, and payment shall be made thereafter in accordance with the terms of the contract but not less frequentlythan once in each succeeding sixty days while the insurer remains liable for the payments if the person insured when required to do so furnishes before payment proof of continuing disability.

12. LIMITATION OF ACTIONS

An action or proceeding against the insurer for the recovery of a claim under this contract shall not be commenced more than one year after the date the insurance money became payable or would have becomepayable if it had been a valid claim.

SPECIAL CONDITIONS

1) In the absence of any legislation in the Province or Territory in which the Insured resides. the StatutoryConditions hereinbefore contained shall nevertheless be deemed conditions applicable to this Policy.
2) No indemnity or benefit (other than for loss of life in circumstances rendering compliance with the terms of thiscondition impossible) shall be payable under this Policy for any loss unless the Insured shall be attended by a legally qualified medical practitioner, nor for any loss which does not occur or commence while this Policy is in force.

3) This Policy shall be incontestable as to the statements contained in the application after it has been in force during the lifetime of the Insured for two years from the Policy date except for such injuries sustained before the expiration of the two-year period.
4) No claim for such injuries sustained after two years from the inception date of the Policy shall be reduced or denied on the ground that a disease or physical condition had existed before the Policy date unless, on the date of sustaining such injuries, such disease or physical condition was specifically excluded from coverage by a waiver clause endorsed hereon.
5) Canadian currency clause: All limits of insurance, premiums, and other amounts as expressed in this Policy are in Canadian currency

Appendix D - Common Questions Asked Regarding Participant Accident Insurance

1) When will I get paid/reimbursed?

Due to the processing time involved, payment for the reimbursement of claims may be anywhere from four to six weeks. If there is indication that further receipts will be submitted, rather than reimburse a claimant for one or two, the insurance company may wait and process a cheque for them all at one time. Some common reasons for delay in payment are:

A. if the injured athlete has other insurance (this policy is a "second payer" and will come into effect after all other insurance available to the athlete is exhausted);
B. the address on the claim form for the athlete is incorrect or incomplete;
C. no physician's referral and receipts have been received;
D. there is no indication that the initial treatment was received within 30 days of the accident;
E. the claim was submitted after 90 days of the accident date.

2) Are braces covered?

Yes, however, there must be a **written prescription** by a licensed doctor in order for air casts/braces, etc. to be insured. **Proof of purchase is not evidence of a prescription**. Air casts/braces, etc. required primarily for sports activities are **not covered**. They must be required for **daily wear** to **rehabilitate**.

3) Can the Physiotherapist refer claimant for treatment?

No. A licensed doctor must refer claimant. The injured athlete must be referred to a Physiotherapist, Chiropractor, Athletic Therapist or Massage Therapist in order for expenses to be reimbursed.

4) IS PHYSIOTHERAPY (CHIROPRACTIC, ATHLETIC THERAPY) COVERED?

There is a medical expense reimbursement coverage u to $15,000 as a result of a covered accident within 52 weeks of the date of accident for:

- licensed athletic therapists, physiotherapist, chiropractor, osteopath and registered nurse services or any other similar services approved by the Insurer in writing and NOT covered under any federal, provincial government or private health care plan.

5) Do I need extra coverage for TRAVELING?

It is **strongly recommended** to purchase a separate emergency travel medical policy for travel outside the province of Manitoba.

Participant accident coverage is limited to accidents that occur within Canada in a sanctioned game or practice. The participant accident does not extend to the USA or anywhere else outside of Canada.

Definition: Emergency travel medical insurance is insurance that can provide you and your team coverage if you or another athlete/coach/manager/volunteer/parent is injured or experiences a medical emergency while travelling outside of your **home province**.

Please note; When you leave your home province or travelling to another province for competition – or when you leave Canada, the Manitoba Provincial Health Insurance will NOT extend or provide coverage to you when travelling.

If you sustain an injury outside of Canada. There is no coverage under the current Sport Manitoba group insurance plan to cover on-going medical treatment of your injury. For example, if you visit California and break your leg, you will not have "insurance" coverage for physiotherapy.

6) How long can I claim expenses?

Up to one year from the date of the accident.

7) Is ambulance covered?

Yes (Ground Ambulance Only)

8) DO I HAVE TO WAIT UNTIL I HAVE ALL OF MY RECEIPTS BEFORE SUBMITTING MY CLAIM?

No. You may submit your claim form and physician's referral first so that the insurer receives your claim within 90 days of the accident. Once your claim has been processed, any receipts can be submitted on an ongoing basis (up to one year after the accident date) directly to your Provincial Sport Organization (PSO). If insurer receives just the athlete accident claim form and physician's referral, they will open your file and await any receipts. If after a period of time no receipts have been submitted, a form letter will be sent to you requesting any receipts.

9) WHAT HAPPENS IF GAMEDAY (INSURER) INSURANCE RECEIVES A CLAIM PAST 90 DAYS OF THE ACCIDENT DATE?

Claim will be denied. However, claims received past 90 days may be considered if the insurer feels that the reason for the delay is justified. (A letter of explanation for the delay should accompany the claim.)

10) IF I HAVE OTHER INSURANCE, DO I SUBMIT MY EXPENSES TO THAT COMPANY FIRST?

Yes. However, in order for a claim to be processed, the insurer must receive a completed participant accident claim form and physician's referral **within 90 days** of the accident date. There is a section on the claim form that asks if there is other insurance. This will indicate to the insurer that the balance of receipts not paid will be forwarded once all other insurance is exhausted.