

ALLSPORT ATHLETIC ACCIDENT CLAIM FORM



| | | |
|---------------------------------|-----------------------|-------------|
| SECTION 1 (please print) | | |
| Last Name of Claimant | First Name | Birth Date |
| Parent or Guardian (if minor) | | |
| Mailing Address | | |
| City | Province | Postal Code |
| Home Phone () | Business Phone () | |

| | |
|---|--|
| SECTION II | |
| Date of Accident (must be completed) _____, 20____ | Location of Accident |
| What is the injury? | |
| Date of First Treatment | <i>(Note: A Physician's referral must be included with receipts for services provided by a physiotherapist, athletic therapist, chiropractor, massage therapist or osteopath).</i> |
| Name of Hospital taken to (if applicable) | Date of Admittance _____, 20____ |
| Date of Discharge _____, 20____ | Attending Physician or Dentist |

| |
|---|
| SECTION III Describe fully how the accident happened |
| |

| | |
|--|--|
| SECTION IV (the sport accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses) | |
| Are you covered for any of these expenses under any other medical plan? (If no, please give an explanation). If yes, you must submit a claim to that plan first. DO NOT LEAVE THIS SECTION BLANK | |
| Name Employer (if applicable) | Name of Insurer (i.e. Blue Cross/Sun Life/Great West Life) |

| | |
|--|------|
| SECTION V | |
| I hereby certify that all the information provided above is correct. | |
| Claimant/Guardian Signature | Date |

| | |
|--|--------------------|
| CERTIFICATION OF ASSOCIATION OR CLUB - Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section. | |
| Name of Team | |
| League or Association | Type of Sport |
| Policy Number: ACL5090 | |
| Was above player a registered member at time of injury? | Yes/No |
| Was player injured while taking part in an authorized activity? | Yes/No |
| Name | Position with Club |
| Signature | Telephone |

Send completed form, physician's referral & receipts for expenses incurred to your Provincial Sport Organization (PSO) (i.e. Football Manitoba, Softball Manitoba), 145 Pacific Avenue, Winnipeg, MB R3B 2Z6. (Manitoba Soccer Association address: 211 Chancellor Matheson Rd, Winnipeg, MB R3T 1Z2). It is the responsibility of the PSO after verification of membership to file the claim with Sport Manitoba. If you do not have any expenses at this time, please forward the forms only. Receipts for expenses can be forwarded directly to Sport Manitoba. Any inquiries can be directed to Sport Manitoba at 925-5645.

| | |
|--|-----------|
| EXECUTIVE DIRECTOR OF PROVINCIAL SPORT ORGANIZATION | |
| Name | Signature |
| Address: | Phone |

| | |
|--|--|
| CERTIFICATION OF SPORT ELIGIBILITY – SPORT MANITOBA | |
| Signature | |

SPORT ACCIDENT INSURANCE POLICY

The Sport Accident Insurance Policy provides coverage when there is bodily **injury** resulting directly from a single sports **accident**.

"An accident is: a single happening due to external, violent, sudden, fortuitous causes beyond the Insured's control.

"An injury is: a bodily injury suffered by a member caused directly by a single sport accident as described above, independent of any sickness or other causes"

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.

INSTRUCTIONS FOR SUBMITTING ATHLETIC ACCIDENT CLAIM FORMS

This insurance coverage is an excess payer. Expenses eligible under any other health care plan(s) must be submitted to that plan(s) first. This policy will pay only the amount of expenses that are not eligible with any other insurer.

1. Claimant completes **Sections I to V** on claim form.
2. Club or League President, Coach or Manager **must** complete **Certification of Association or Club**.
3. Submit claim form to the Provincial Sport Organization you are a member of (i.e. Soccer, Baseball, Softball, Football), for the Executive Director to certify eligibility of claimant and team.
4. Attach all receipts for services, including a physician's referral and if applicable, statement from primary insurer outlining amount paid.
5. Executive Director submits claim to Sport Manitoba to certify eligibility of sport association. Sport Manitoba forwards claim to Markel-All Sport Insurance Marketing Ltd for processing. (Claimant then can communicate directly with insurance company.)

IMPORTANT INFORMATION TO NOTE WHEN SUBMITTING CLAIM:

1. An Athletic Accident Claim Form **must be received by Markel-All Sport Insurance Marketing Ltd. within 90 DAYS** of the accident date. **A Physician/Dentist must have been consulted within 30 DAYS** of the accident date.
2. You must provide all information requested; **incomplete** claim forms will not be processed. Important - Include full address, that is, **city** and **postal code**. Do not leave any questions blank or form will be considered incomplete and returned.
3. Itemized statements and paid receipts (**originals are required if there is no other coverage available**) should indicate the patient's name, name of medication prescribed, type of purchase or service, date of each purchase or service, and amount charged for each purchase or service. Once claim is submitted, eligible expenses as a result of the injury can be claimed for up to one year after the accident date.
4. If payment should be made to anyone other than the claimant, please indicate so on the receipts/information submitted.
5. **Some benefits covered under this policy are:** physiotherapist, athletic therapist, chiropractor, massage therapist, osteopath, prescribed drugs, ambulance, vision care, dental, and medical braces. (For benefits not mentioned, please contact Sport Manitoba) Hospital room accommodation is not an eligible expense.
6. **Medical braces prescribed for rehabilitation (daily wear) purposes are "covered", but medical braces required primarily for sporting type activities are "not covered"**. Notification from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace, and the type of brace prescribed must be submitted with your receipt.
7. **A Physician's referral must be included with the receipts for the services provided by a physiotherapist, athletic therapist, chiropractor, massage therapist or osteopath.**
8. Vision care expenses can be claimed if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to a sport related accident. An explanation must be submitted with your receipt to claim the limited benefit.
9. This policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not.

IF YOU REQUIRE FURTHER INFORMATION OR HAVE ANY CLAIM INQUIRIES, PLEASE CONTACT SPORT MANITOBA at (204) 925-5645.