MARKEL CANADA LIMITED ATHLETIC ACCIDENT CLAIM FORM

OMNI HOCKEY

FORMS AND ALL RECEIPTS TO BE SUBMITTED TO:
OMNI Hockey
Suite 600, 1420 Blair Place, Ottawa, ON K1J 9L8
Tel: (613) 745-1352 / (888) 361-1352
Fax: (613) 244-3755

SECTION I (please print)

Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone ( )	Business Phone ( )	

SECTION II

Date of Accident	Hour a.m. / p.m. (circle one)
Location of Accident	
What is the injury?	
Date of First Treatment	
Name of Hospital taken to	
Date of Admittance	Hour a.m. / p.m. (circle one)
Date of Discharge	Name of Attending Physician or Dentist

SECTION III Describe fully how the accident happened.

SECTION IV (your sport accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses)
What medical coverage do you have through your/spouse/parent employment?

Name of Employer	Name of Insurer
Address of Employer	Address of Insurer
City Prov. Postal Code	

SECTION V
I hereby certify that all the information provided above is correct.

Claimant's / Guardian's Signature Date

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CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE
Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section.

Name of Team	League or Association
	OMNI Hockey
Accident Policy No. **CAS841821-01**	Type of Sport **Contact & Non-Contact Hockey**

Was the above player registered at the time of the injury? Yes/No (circle one)

Was the player injured while taking part in an authorized activity? Yes/No (circle one)

Lawrie INSURANCE GROUP

INSTRUCTIONS

You must provide all information requested; incomplete forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. OMNI Hockey must receive notice of your accident within 30 days of the accident date and receive claim documentation within 90 days.

2. ALL claims must be submitted with itemized statements and paid receipts **(originals are required if there is no other coverage available),** which indicate
   - Patient's name
   - Type of purchase or service
   - Date of each purchase or service
   - Amount charged for each purchase or service

3. A physician statement confirming diagnosis and recommended treatment is required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible specified in your plan will be considered for payment up to your maximum benefits.

5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sport accident policy will pay only the amount of expenses that are not eligible with any other insurer.

- IF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM: (Please check your plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

- FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

A. PRESCRIBED DRUGS
   - Name of medication or drug
   - Date of purchase
   - Amount charged

B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
   - Physician referral
   - Type of service
   - Date of each treatment
   - Amount charged for each treatment
   - Date of treatment paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION
   - Not an eligible expense

D. AMBULANCE (Emergency to Hospital only)
   - Date of service
   - Places ambulance taken from and to
   - Amount charged

E. VISION CARE
   - If your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
   - An explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY
   - If your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable
   - A statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES
   - A letter 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
   - Medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS
   - Exact date of accident
   - Breakdown of services performed
   - Circumstances surrounding the accident
   - Is there other dental coverage? Enclose details.
   - Confirmation that treatments only relate to the accident
   - Provide other insurer's explanation
   - Are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
   - Your Sport Accident Policy does not make payment for any services or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not

ALL FORMS AND RECEIPTS TO BE SUBMITTED TO: OMNI Hockey. If you do not have invoices currently, please forward the form only to confirm that you intend to make a claim. Any concerns with the completion of the form can be addressed with the OMNI Hockey Claims Adjuster once your claim has been received. For assistance completing this form, please contact info@omnihockey.ca

Lawrie
INSURANCE GROUP

PART 1 DENTIST

Dentist's Name _____

Address _____

City, Province _____

Postal Code _____

Telephone _____

Patient's Last Name _____ Given Names _____

Address _____ Apt. _____

City, Province _____

Postal Code _____

Date of Service D M Y	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00

This is an accurate statement of services performed and fees charges. E. & OE.	Total Submitted Fee
Dentist's Signature	Date: Day Month Year

FOR DENTIST'S USE ONLY.

For additional information Re: diagnosis, procedures or complications and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.	I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.
Signature of Patient (or Parent/Guardian)	Signature of Subscriber

FOR PLAN ADMINSTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note – Under the terms of the Policy, this report must be forwarded to OMNI Hockey within 90 days of the date of the accident. Your co-operation will be appreciated.

CLAIM APPROVED:

Day Month Year

Assessor

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage _____

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated – use procedure code if possible	Est. Date – Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame. _____

Date: Day Month Year

Dentist's Signature _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Discharged: _____

If referred to you, give name of referring physician:

Operations (or other procedures performed): _____ _____

Date: _____

Date: _____

Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ Date of Accident: _____

Has the patient ever had same or similar condition? _____

If yes, please state when and describe: _____

Is there any other disease or infirmity affecting the present condition?

Date: _____ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____