



ALLSPORT INSURANCE MARKETING LTD.

417 - 1367 West Broadway
Vancouver, BC V6H 4A9
Phone (604) 737-3018
Fax (604) 737-3076

ATHLETIC ACCIDENT CLAIM FORM

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

SECTION III	Describe fully how the accident happened.

SECTION IV (your sports 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	
City	Prov.	Postal Code	Policy No. Certificate

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

Send completed form along with any invoices for expenses you had to pay yourself to All Sport Insurance Marketing Ltd., 417 - 1367 West Broadway, Vancouver, BC V6H 4A9 Phone (604) 737-3018 Fax (604) 737-3076. Please do not hesitate to call All Sport if you have any questions regarding this form. Instructions are on the reverse side. If you do not have costs at this time, please forward the form only and confirm that you intend to make a claim.

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
Group Policy No.	Type of Sport
Was the above player a registered member at the time of injury?	Yes/No
Was the player injured while taking part in an authorized activity?	Yes/No
Name	Position with Club
Telephone No.	Signature

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: _____