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, Team or League Representative 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, Team or League Representative for Signature

PARTICIPANT ACCIDENT CLAIMS FORM

IMPORTANT INFORMATION, INSTRUCTIONS, & DEADLINES

IMPORTANT INFORMATION

Participant accident is NOT primary medical insurance. In order to make a claim, provincial health care and any extended health benefits must be exhausted before you submit a claim. Participant accident insurance is an insurance policy provided as a benefit from the organization you belong to. It is NOT intended to replace any extended benefits plan. All participant accident claims will be processed and recorded as an insurance claim. This can and will affect the renewal premiums.

INSTRUCTIONS

- Complete the attached **PARTICIPANT ACCIDENT CLAIMS FORM** and **PHYSICIAN STATEMENT**.
- If your claim is for dental injury, have your dentist complete and submit a predetermination form
- If you intend to make a claim but have not had out of pocket expenses to date, complete and submit claim form indicating that receipts are to follow
- Forward forms along with original copies of expenses receipts to date to your Association for Signature
- Email claim forms and receipts to claims@sbcinsurance.com
- The claims form and receipts will be submitted on your behalf to the insurance company and claims department.

TIMELINES/DEADLINES

Notification: The insurance company must receive notification of your accident within 30 days of it occurring.

Claims form Submission: The insurance company must receive the claim form within 90 days of the accident.

Where to submit your claim forms, physician statement & receipts:
claims@sbcinsurance.com
You will receive an automatic reply once your email is received. If your claim forms and physician statement are fully complete, the claim forms and physician statement will be submitted on your behalf. An adjuster representing the insurance company will reach out to you. Please ensure you have all your contact details *(phone # and email)* legible on the claim forms.