# SPORT ACCIDENT CLAIM 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) _____

Home Phone _____ Daytime Phone Number: _____

Email address _____

Date of Accident (mm/dd/yyyy) _____

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? Yes or No

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 (mm/dd/yyyy) _____

**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 (mm/dd/yyyy) _____

See Instruction Page for further details on submitting claims

# PHYSICIAN'S STATEMENT

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician Statement

Full of Patient _____

Date of Birth (mm/dd/yyyy) _____ Male / Female _____

Mailing Address including City and Postal Code

_____

Date of Visit (mm/dd/yyyy)_____

Complete description of the injury and your diagnosis

If hospital was required, give the name of facility _____

Date admitted (mm/dd/yyyy) _____ Discharge date (mm/dd/yyyy) _____

Name of referring physician, if any _____

Physician Name _____

Signature _____

Address_____

Date (mm/dd/yyyy) _____