



**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 \_\_\_\_\_

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



## PHYSICIAN'S STATEMENT

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



## ACCIDENT CLAIM FORM INSTRUCTIONS

- ⇒ AJ Gallagher Canada, Ltd. must receive notification of your accident within 30 days of it occurring and receive your claim form within 90 days of the accident.
- ⇒ Complete attached Sport Accident Claim Form and Physician Statement. If your claim is for dental injury have your dentist complete and submit a Predetermination Form.
- ⇒ Claims Forms can be submitted to our office electronically or by fax. If you are submitting the forms by mail, please forward copies only and retain originals for your files.
  - AJ Gallagher Canada, Ltd.  
435 McNeilly Road, Suite 203  
Stoney Creek, ON L8E 5E3  
Attention: Sports and Recreation Department  
Phone: 1-800-461-5087 Ext 122 Fax: 905-643-8321  
Email: [IBAM.StoneyCreek.Sports@ajg.com](mailto:IBAM.StoneyCreek.Sports@ajg.com)
- ⇒ 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.
- ⇒ If you have questions regarding submission of forms, please contact AJ Gallagher Canada, Ltd's Sports and Recreation Department..