SPORT ACCIDENT CLAIM FORM

Claim must be submitted with 90 days of accident
To Be Completed By Player or Parent

Full Name of Insured Player ____________________ Date of Birth ____________________

Address ____________________

Sports Association, League or Team Name ____________________

POLICY NUMBER ____________ Accident date ____________ Time ________ AM/PM

Location of Accident ____________________

How Did Accident Occur? ____________________

Names of Witnesses ____________________

Describe Nature of Injury ____________________

Name of Doctor ____________________ Bus. Phone # (   ) ____________

Address of Doctor ____________________

Give Dates of All Medical Treatments ____________________

If Hospitalized, Give Name of Hospital ____________________

Player or Parent Signature ____________________ Date ____________ Phone ____________

IMPORTANT: ALL BILLS FOR WHICH COVERAGE EXISTS UNDER THE POLICY MUST BE SUBMITTED
IN THE EVENT OF A DEATH CLAIM, A CERTIFIED COPY OF DEATH CERTIFICATE MUST BE SUBMITTED

MEDICAL REPORT AUTHORIZATION

In connection with injuries sustained by ____________________ *(Name of Player)* as a result of an accident occurring on ____________ 20____ at or near ____________________ *(Location).*
This is your authority to provide the insurance company with

1) A report including Diagnosis, History of Treatment and Prognosis and
2) To allow an inspection of all hospital records related to injuries received in the accident.

Player or Parent Signature ____________________ Date ____________

****** Have the following section completed by attending physician MANDATORY**

1) Extent of Injury ____________________
2) Description of Treatment ____________________
3) Future Treatment (If any) ____________________

Physician's Signature ____________________ Date ____________

IF THERE IS A CHARGE FOR COMPLETING THIS FORM, IT IS THE RESPONSIBILITY OF THE PATIENT

PLEASE REMIT TO:

CLAIM FOR DENTAL EXPENSE BENEFITS

DENTIST		Patient
D E N T I S T	Name ______ Address ______ City & Province ______ Postal Code ______ Telephone Number ______ Social Insurance Number ______	Patient's Last Name Given Names ______ Address ______ City Province ______ Postal Code ______

Date of Service	Tooth Code	Procedure Code	Tooth Surfaces	Lab Charges	Dentist Fee	Total Charge
				TOTAL FEE: $		

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED

______ ______
Dentist's Signature **Date**

FOR DENTIST USE ONLY. FOR ADDITIONAL INFORMATION RE: DIAGNOSIS PROCEDURES, OR COMPLICATIONS, AND SPECIAL CONSIDERATIONS.

______
______
______
______
______
______

I understand that the fees listed in the 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.

______
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

I hereby assign my benefits payable from this claim to the above named dentist and authorize payment directly to him.

______
SIGNATURE OF SUBSCRIBER

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

DENTIST

Is any of the treatment for Orthodontic purposes?
❑ Yes ❑ No

Was the treatment the result of injury?
❑ Yes ❑ No

I hereby certify that the services listed have been
Performed ❑ Planned ❑

If future treatment is planned please indicate estimate date and cost in the additional information section.

______
______
______
______
______

PARENT OR GUARDIAN

Were these teeth whole or sound at time of accident?
❑ Yes ❑ No

Were these permanent teeth?
❑ Yes ❑ No

Are any dental benefits or services provided under any other insurance or dental plan?
❑ Yes ❑ No

Name of Insuring Agent:
______

Policy Number:
______

Describe dental injury sustained: ____
______
______
______
______

OTHER INSURANCE DECLARATION

The Insurance Policy as purchased by your sports organization provides for coverage in excess of any private or government medical / dental plan.

If you incur medical or dental expenses as the result of a sports injury, you are required to submit those expenses to your own private medical/dental plan first.

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts of expenses not covered, to your sports association for processing.

Please clarify your situation by checking one of the following:

_____ Yes, I have private coverage and will be submitting my claim directly to my private insurers.

______ Yes, I have private coverage, but I do not believe that they will provide full reimbursement and would ask that you keep my claim open until we receive notification from the private insurers.

______ No, I do not maintain any private medical/dental coverage. The expenses I am submitting are not covered by any other plan.

If you are a minor then your parents or legal guardian must complete this form on your behalf.

Name – print ______________________________

Signature ______________________________

Date (mm/dd/yyyy) ______________________________

If the claim is being submitted for a minor, please indicate the name.

Name – print ______________________________

THIS FORM IS TO BE SUBMITTED WITH EVERY SPORTS ACCIDENT CLAIM FORM, DULY COMPLETED AND SIGNED.

ACCIDENT INCIDENT REPORT FORM
LACROSSE

PLEASE COMPLETE THIS FORM WHENEVER A LACROSSE ACCIDENT OCCURS WHICH REQUIRES SOME FORM OF MEDICAL ATTENTION. INCLUDES ATHLETES, OFFICIALS, COACHES AND VOLUNTEERS, ETC. THIS FORM MUST ACCOMPANY ANY MEDICAL OR DENTAL CLAIM.

SEND IMMEDIATELY TO:

ONTARIO LACROSSE ASSOCIATION
1185 Eglinton Ave. E., Suite 607
North York, ON M3C 3C6

Phone: (416) 426-7066 Fax: (416) 426-7382

The information which you provide on this form allows us to establish causes of and types of injuries related to lacrosse as part of a long term research effort to improve preventative measures.

Please indicate activity in which injured person was participating:

- ☐ Practice
- ☐ Game
- ☐ Sanctioned Tournament
- ☐ Non-Sanctioned Tournament

Please state whether the activity was: ☐ Indoor ☐ Outdoor

Name of Injured Person: ____
Surname Given Name

Address: ____

City: ____________________ Province: __________ Postal Code ____________

Phone # ( )__________ Age ______ Date of Birth ____________ Male ___ Female ___

Date of Accident ________________ Location of Accident __________________

Club Name ____________________ Address______________________________

Team Name ____________________ League Name ________________________

Age Group: Under 18 _____ Over 18 _____

PLEASE CHECK APPROPRIATE BOX TO DESCRIBE ACCIDENT:

- ❑ Collision with another player
- ❑ Collision with goalie
- ❑ Collision with net
- ❑ Collision with boards
- ❑ Trip (no contact)
- ❑ Hit with stick
- ❑ Hit with ball
- ❑ Hit from behind
- ❑ Jumping over player
- ❑ Surface problem

If hit with stick, what type of stick: ❑ Plastic stick ❑ Wood stick

Was a foul called: ❑ YES ❑ NO
Against you: ❑ YES ❑ NO
What Infraction:

- ❑ Fighting
- ❑ Dangerous play
- ❑ Roughing
- ❑ Tackling
- ❑ Tripping
- ❑ Other ____________________

PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING:

- ❑ Helmet no mask
- ❑ Helmet full mask
- ❑ Full mouth guard
- ❑ Other gloves
- ❑ Kidney pads
- ❑ Shoulder pads
- ❑ Elbow pads
- ❑ Shin pads
- ❑ Knee pads
- ❑ Lacrosse gloves

PLEASE INDICATE TYPE OF INJURY: (this accident)

- ❑ Dental
- ❑ Muscle pull
- ❑ Torn ligament
- ❑ Concussion
- ❑ Sprain (joints)
- ❑ Dislocation
- ❑ Fracture
- ❑ Internal Injury
- ❑ Laceration
- ❑ Bruise
- ❑ Skin (wound/puncture)
- ❑ Torn cartilage

PLEASE INDICATE THE BODY PARTS INJURED: (this accident)

- ❑ Knee
- ❑ Face
- ❑ Chest
- ❑ Nose
- ❑ Ear
- ❑ Hip
- ❑ Fingers
- ❑ Chin
- ❑ Shoulder
- ❑ Hamstring
- ❑ Teeth
- ❑ Foot
- ❑ Wrist
- ❑ Elbow
- ❑ Thumb
- ❑ Hand
- ❑ Spine
- ❑ Thigh
- ❑ Head
- ❑ Mid Section
- ❑ Ankle
- ❑ Neck
- ❑ Eye
- ❑ Calf
- ❑ Back
- ❑ Upper arm
- ❑ Achilles Tendon
- ❑ Collar bone
- ❑ Other ____________________

LACROSSE ACTIVITY: (this accident)

A) FIELD LACROSSE:

Position played: ❑ Forward ❑ Goal

This accident happened in the:
❑ 1st quarter ❑ 2nd quarter ❑ 3rd quarter ❑ 4th quarter

B) BOX LACROSSE:

Position played: ❑ Middie ❑ Attack ❑ Defense ❑ Goal Keeper

This accident happened in the: ❑ 1st period ❑ 2nd period ❑ 3rd period

OTHER CONDITIONS:

GAME PLAYED: ❑ Morning ❑ Afternoon ❑ Evening

WEATHER CONDITIONS: ❑ Sunny ❑ Cloudy ❑ Rain
❑ Other ____________________
❑

TEMPERATURE - CELCIUS:
❑ Below 0 ❑ 0-10 ❑ 10-20 ❑ 20-25 ❑ 26-33 ❑ plus 33

PLAYING SURFACE:
❑ Wood ❑ Grass ❑ Concrete ❑ Rubberized ❑ Artificial Turf
❑ Other ____________________

LOCATION:
❑ Gymnasium ❑ Community Centre ❑ Arena ❑ School

HOW LONG HAS INDIVIDUAL BEEN ACTIVE IN LACROSSE:

As a player _____ years As a coach _____ years As a referee _____ years

WAS INJURED PERSON TREATED ON SITE OR REFERRED FOR PROFESSIONAL MEDICAL/DENTAL TREATMENT?

On Site: ❑ Yes ❑ No

If "yes", treated by whom? ______________________
Name

____
Position

Professional medical/dental treatment? ❑ Yes ❑ No

If "yes" Name of **Witness**: ______________________
Full Address: ______________________

____

Phone Number: ( ) ______________

______________________ ______________________
Submitted by (Signature) **Address**

______________________ ______________________
Position **Date**

NOTE: IF MAJOR ACCIDENT, REQUIRE FULL WITNESS REPORTS AS WELL AS ALL OTHER REPORTS TO BE FORWARDED WITHIN TWENTY-FOUR (24) HOURS.

Place an "X" at area of injury

Place an "O" at your net

Indicate if it was:
❑ Box Lacrosse
❑ Field Lacrosse