GAMEDAY
INSURANCE

# ACCIDENT CLAIM FORM INSTRUCTIONS

⇒ Pearson Dunn Insurance 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.

- Pearson Dunn Insurance Inc.
  435 McNeilly Road, Suite 103
  Stoney Creek, ON L8E 5E3
  Attention: Sports and Recreation Department
  Phone: 1-800-461-5087 Ext 122 Fax: 905-643-8321
  Email: jproctor@pearsondunn.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 Pearson Dunn Insurance's Sports and Recreation Department..

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# 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

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# 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 _____