ACCIDENT CLAIM FORM INSTRUCTIONS

⇒ **Gallagher 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.

- **Gallagher Insurance**.

  435 McNeilly Road, Suite 103

  Stoney Creek, ON L8E 5E3

  Attention: Sports Administrator

  Phone: 1-800-461-5087 Fax: 905-643-8321

  Email: 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 our Sports & Recreation Department.

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 ______________________________

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____

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 ____________________

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

____

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____

If hospital was required, give name of facility ______________________

Date admitted ______________ Discharge date ______________

Name of referring physician, if any ______________________

Physician Name ______________________

Signature ______________________

Address ______________________

Date ______________