

# 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

<b>D</b>	Name _____	Patient's Last Name _____	Given Names _____
<b>E</b>	Address _____	Address _____	
<b>N</b>	City & Province _____	City _____ Province _____	
<b>T</b>	Postal Code _____	Postal Code _____	
<b>I</b>	Telephone Number _____		
<b>S</b>	Social Insurance Number _____		
<b>T</b>			

Date of Service	Tooth Code	Procedure Code	Tooth Surfaces	Lab Charges	Dentist Fee	Total Charge
<b>TOTAL FEE: \$</b>						

## 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.

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

\_\_\_\_\_  
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

\_\_\_\_\_  
SIGNATURE OF SUBSCRIBER

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

# 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  
3 Concorde Gate, Suite 306  
Toronto, On M3C 3N7

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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Collision with another player | <input type="checkbox"/> Hit with stick      |
| <input type="checkbox"/> Collision with goalie         | <input type="checkbox"/> Hit with ball       |
| <input type="checkbox"/> Collision with net            | <input type="checkbox"/> Hit from behind     |
| <input type="checkbox"/> Collision with boards         | <input type="checkbox"/> Jumping over player |
| <input type="checkbox"/> Trip (no contact)             | <input type="checkbox"/> 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:

- |   |                                   |                                      |
|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Fighting       | <input type="checkbox"/> Roughing | <input type="checkbox"/> Tripping    |
| <input type="checkbox"/> Dangerous play | <input type="checkbox"/> Tackling | <input type="checkbox"/> Other _____ |

**PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Helmet no mask   | <input type="checkbox"/> Kidney pads   | <input type="checkbox"/> Shin pads       |
| <input type="checkbox"/> Helmet full mask | <input type="checkbox"/> Shoulder pads | <input type="checkbox"/> Knee pads       |
| <input type="checkbox"/> Full mouth guard | <input type="checkbox"/> Elbow pads    | <input type="checkbox"/> Lacrosse gloves |
| <input type="checkbox"/> Other gloves     |  |  |

**PLEASE INDICATE TYPE OF INJURY: (this accident)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Dental        | <input type="checkbox"/> Concussion      | <input type="checkbox"/> Fracture        | <input type="checkbox"/> Bruise                |
| <input type="checkbox"/> Muscle pull   | <input type="checkbox"/> Sprain (joints) | <input type="checkbox"/> Internal Injury | <input type="checkbox"/> Skin (wound/puncture) |
| <input type="checkbox"/> Torn ligament | <input type="checkbox"/> Dislocation     | <input type="checkbox"/> Laceration      | <input type="checkbox"/> Torn cartilage        |

**PLEASE INDICATE THE BODY PARTS INJURED: (this accident)**

- |                                      |                                    |                                |                                      |                                |  |
|--------------------------------------|------------------------------------|--------------------------------|--------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Knee        | <input type="checkbox"/> Hip       | <input type="checkbox"/> Teeth | <input type="checkbox"/> Hand        | <input type="checkbox"/> Ankle | <input type="checkbox"/> Back            |
| <input type="checkbox"/> Face        | <input type="checkbox"/> Fingers   | <input type="checkbox"/> Foot  | <input type="checkbox"/> Spine       | <input type="checkbox"/> Neck  | <input type="checkbox"/> Upper arm       |
| <input type="checkbox"/> Chest       | <input type="checkbox"/> Chin      | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh       | <input type="checkbox"/> Eye   | <input type="checkbox"/> Achilles Tendon |
| <input type="checkbox"/> Nose        | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head        | <input type="checkbox"/> Calf  | <input type="checkbox"/> Collar bone     |
| <input type="checkbox"/> Ear         | <input type="checkbox"/> Hamstring | <input type="checkbox"/> Thumb | <input type="checkbox"/> Mid Section |                                |  |
| <input type="checkbox"/> Other _____ |                                    |                                |                                      |                                |  |

**LACROSSE ACTIVITY:** (this accident)

**A) FIELD LACROSSE:**

Position played:     Forward                       Goal

This accident happened in the:

1st quarter       2<sup>nd</sup> quarter       3<sup>rd</sup> quarter       4<sup>th</sup> quarter

**B) BOX LACROSSE:**

Position played:     Middle     Attack     Defense     Goal Keeper

This accident happened in the:     1st period     2<sup>nd</sup> period     3<sup>rd</sup> 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

A large rectangular box for drawing the injury site. It contains two horizontal lines, one near the top and one near the bottom, likely representing the net or goal area.

**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.**