PARTICIPANT ACCIDENT CLAIMS 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) ___________________________

HomePhone#______________________ **DaytimePhone#**______ ____________________

Cell Phone # ____

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

Please Return Completed Form to Your Sport Association, Team or League Representative for Signature

PHYSICIAN'S STATEMENT

Please complete this form and return to patient. **Patient's accident claim cannot be processed without the completed Physician and/or Dentist 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 ______________________

Please Return Completed Forms to Your Sport Association, Team or League Representative for Signature