Proof of Loss – Accidental Medical (Sports Insurance)

the citadel

Please answer all questions fully – it helps us to provide better service.

Instructions: Injured Member complete Insured Statement Section; Team Manager or Administrator complete Club Section at bottom of page 1. Attending Physician complete Physician Statement Section on page 2.

Important: If Injury involves teeth, please complete Accidental Dental Claim Form. If the Member is covered under any other Medical insurance plan, the expenses must be submitted to that plan. If there is any unpaid balance, please attach their Payment Statement.

Note: All questions can be completed in ink (please print) or on-line by each of these parties, however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned along with ORIGINAL medical receipts to **The Citadel General Assurance Company** at any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5
2001 University Street, Suite 1850, Montreal, Quebec H3A 2L8
355 – 4th Avenue S.W., Suite 700, Calgary, Alberta T2P 0J1

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes

Insured Statement Section

Policy Number: 9222591

1. Insured Member's Full Name
2. Date of Birth D M Y
3. If a Minor, give Full Name of Parent or Guardian
4. What is your occupation outside of your sports activities?
5. Employer

   Address

   Street City Province Postal Code

6. Name of Team for which you were playing
7. Type of Sport
8. Date of Accident D M Y
9. Date first treated by doctor D M Y
10. Where did accident occur?
11. Was it during an approved ☐ practice ☐ game ☐ travelling
12. Describe injury
13. Describe fully how accident occurred
14. Full Name of Physician who first treated you

    Address

    Street City Province Postal Code

15. Full Name(s) and address(es) of other doctor(s) who treated you
16. Name of hospital if treated in hospital
17. Date treated in hospital D M Y
18. Do you have any other Hospital or Medical Insurance? ☐ Yes ☐ No — Plan Name/Policy Number

I certify to the best of my knowledge that the statements made above are true, correct and complete.

Injured Member's Signature (or Signature of Parent or Guardian if injured member is a minor)

( ) Telephone

D M Y Date

Complete Address

Street City Province Postal Code

Club Section

1. Name of Team
2. **Policy Number**
3. Name of League or Association
4. What sport is team engaged in
5. On what date did player join the team D M Y
6. Was the above player a regular member at the time of injury ☐ Yes ☐ No
7. Was the player injured during an approved activity? ☐ Yes ☐ No

   If yes, an approved ☐ practice ☐ game ☐ travelling

Authorized Signature | Print Name | Official Position/Title

Complete Address

Street | City | Province | Postal Code

Telephone ( )

Date D M Y

Attending Physician Statement Section

Page 2 **Policy Number** ....

1. Patient's Name ______ 2. Patient's Age ......

3. Diagnosis of present condition ......
   (a) Primary ......
   (b) Secondary (if applicable) ......

4. On what dates did you examine the patient? D M Y | D M Y | D M Y

5. To the best of my knowledge
   (a) Symptoms first appeared or accident happened D M Y
   (b) Patient has had same or similar condition? ☐ Yes ☐ No
   If "Yes", state particulars ......

6. If attended at hospital, name of hospital ______
   Admitted D M Y Time ______ AM/PM
   Discharged D M Y Time ______ AM/PM

7. If surgery performed, describe ______

8. If patient referred to you, give name of referring physician ______

9. Have you referred the patient to a specialist for additional treatments? ☐ Yes ☐ No
   If "Yes", please explain ______

10. Have you referred the patient for physiotherapy treatments? ☐ Yes ☐ No If yes, date such referral was made: D M Y
    Frequency and duration of physiotherapy treatments? ______

Physician's Name (Print) ...... Physician's Signature ......

Address ......
Street City Province Postal Code

Telephone ( ) ...... Date D M Y

I hereby authorize the release to my Insurer and my Policyholder of any information requested in respect of the claim.

Signature of Patient ______ Date D M Y

The patient is responsible for securing the form and for charges made for its completion.