OMNI HOCKEY

FORMS AND ALL RECEIPTS TO BE SUBMITTED TO: OMNI Hockey

Suite 600, 1420 Blair Place, Ottawa, ON K1J 9L8 Tel: (613) 519-2294 info@omnihockey.ca

MARKEL CANADA LIMITED ATHLETIC ACCIDENT CLAIM FORM

SECTION I (please print) Last Name of Claimant	First Name	Birth Date					
Mailing Address							
City	Province	Postal Code					
If a Minor, Name of Parent							
Home Phone	Business Phone						
	()						

SECTION II	
Date of Accident	Hour a.m. / p.m. (circle one)
Location of Accident	
What is the injury?	
Date of First Treatment	
Name of Hospital taken to	
Date of Admittance	Hour a.m. / p.m. (circle one)
Date of Discharge	Name of Attending Physician or Dentist
SECTION III Describe fully how the	ccident happened.
SECTION IV (your sport accident policy is What medical coverage do you have throu	an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses) In your/spouse/parent employment?
Name of Employer	Name of Insurer
Address of Employer	Address of Insurer
City Prov.	Postal Code

SECTION V

I hereby certify that all the information provided above is correct.

Claimant's / Guardian's Signature Date

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CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE

Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section.

Name of Team League or Association

OMNI Hockey

Accident Policy No. Type of Sport

CAS841821-01 Contact & Non-Contact

Hockey

Was the above player registered at the time of the injury? Yes/No (circle one)

Was the player injured while taking part in an authorized activity? Yes/No (circle one)

INSTRUCTIONS

You must provide all information requested; incomplete forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

- OMNI Hockey must receive notice of your accident within 30 days of the accident date and receive claim documentation within 90 days.
- ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate
 - · Patient's name
 - Type of purchase or service
 - Date of each purchase or service
 - Amount charged for each purchase or service
- 3. A physician statement confirming diagnosis and recommended treatment is required if you are claiming other than dental or ambulance expense.
- Only claims in excess of the deductible specified in your plan will be considered for payment up to your maximum benefits.
- 5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sport accident policy will pay only the amount of expenses that are not eligible with any other insurer.
- IF YOU ARE CLAIMING ANY OF THE BENEFITS
 LISTED BELOW, YOU MUST INCLUDE THE
 FOLLOWING INFORMATION WITH YOUR CLAIM:
 (Please check your plan details for the conditions
 under which these benefits are eligible. You must
 have required and received medical/dental treatment
 commencing within 30 days of the accident date.)
- FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE
 - A. PRESCRIBED DRUGS
 - Name of medication or drug
 - Date of purchase
 - Amount charged
 - B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
 - Physician referral
 - Type of service
 - Date of each treatment
 - Amount charged for each treatment
 - Date of treatment paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION

Not an eligible expense

D. AMBULANCE (Emergency to Hospital only)

- Date of service
- Places ambulance taken from and to
- Amount charged

E. VISION CARE

- If your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
- An explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY

- If your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable
- A statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES

- A letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed must be submitted with your receipt
- Medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS

- Exact date of accident
- Breakdown of services performed
- Circumstances surrounding the accident
- Is there other dental coverage? Enclose details.
- Confirmation that treatments only relate to the accident
- Provide other insurer's explanation
- Are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN

 Your Sport Accident Policy does not make payment for any services or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not

ALL FORMS AND RECEIPTS TO BE SUBMITTED TO:

OMNI Hockey. If you do not have invoices currently, please forward the form only to confirm that you intend to make a claim. Any concerns with the completion of the form can be addressed with the OMNI Hockey Claims Adjuster once your claim has been received. For assistance completing this form, please contact info@omnihockey.ca



PART 1 DENTIST Dentist's Name													Pat	ient	s's L	ast	Nam	е	Given Names								
Address														Ad	dres	S				Apt.	Apt.						
City, Province												City, Province															
Postal Code											Postal Code																
Te	Telephone																										
Date of Int. Pro Service Tooth Code			rocec	dure	Code	2	Tooth Surfaces					De	Dentist's Fee		Fee Total Charge					FOR PLAN AD ONLY: NOTICE TO DE		DMINSTRATOR USE ENTIST:	JSE				
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De	ntist	's Si	anat	ure							Da	ite:	Dav	Mc	onth	Ye	ear										
	Dentist's Signature Date: Day Month Year FOR DENTIST'S USE ONLY.																										
For additional information Re: diagnosis, procedures or complications and special considerations.																											
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I understand that the fees listed in this 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.									ned c	denti	nefits payable from this claim to entist and authorize payment							CLAIM APPROVED:									
Signature of Patient (or Parent/Guardian) Signature of Subscriber												'							Day Month Year Assessor								
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Treatment Indicated – use procedure												edure	e coc	le if p	ossil	ble			Day		Mo.	1	Yr.				
2	Describe further potential problems and indicate time frame.																										
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Da	Date: Day Month Year Dentist's Signature																										

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient. Patient's Name: Address: Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated: If Hospitalized, give name of hospital: Discharged: Date Admitted: If referred to you, give name of referring physician: Operations (or other procedures performed): Date: Date: Date of first consultation for above: Date of first symptoms: Date of Accident: Has the patient ever had same or similar condition? If yes, please state when and describe: Is there any other disease or infirmity affecting the present condition? Signature (M.D.) Date: Address: Certified Specialist Phone: