EVEREST INSURANCE COMPANY OF CANADA

130 Bloor Street West, Suite 602
Toronto, Ontario M5S 1N5

Tel: (416) 487-3900 / 1-877-691-1247
Email: laurie.hawdon@everestcanada.com

Fax: (416) 487-0311

ACCIDENT CLAIM FORM INSTRUCTIONS

Everest Insurance Company of Canada must receive your completed claim forms within thirty (30) days of the accident occurring.

- Complete the attached Sport Accident Claims Form and have your Physician complete the Attending Physician Statement. If your claim is for dental injury have your dentist complete the Attending Physician Statement.

- Forward original forms along with copies of expense receipts and statements of reimbursements from your personal insurers to:
  Laurie Hawdon
  Claims Department
  130 Bloor Street West, Suite 602
  Toronto, Ontario
  M5S 1N5
  Phone: 416-480-7357 or 1-877-691-1247 ext: 259
  Fax: 416-487-0311

- Or email PDF copies to laurie.hawdon@everestcanada.com

- If you intend to make a claim but have not had out of pocket expenses to date, complete and submit the claim form indicating that receipts are to follow.

Should you have any questions regarding submission of these forms please, contact Laurie Hawdon at the above.

By furnishing this blank the company makes no admission of liability or waiver of its rights. **To be fully completed and returned within thirty (30) days.**

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ACCIDENT CLAIM REPORT

GROUP POLICY HOLDER		POLICY NUMBER	TYPE OF SPORT PLAYED
CLAIMANT'S FULL NAME		DATE OF INJURY	
STREET ADDRESS	CITY	PROVINCE AND POSTAL CODE	DATE OF BIRTH
OCCUPATION PRIOR TO INJURY	DUTIES	MONTHLY EARNINGS	WEEKLY EARNINGS

1.	Give full description of injury from which you are now suffering. Describe when, where and how it happened:	DESCRIBE:
2. A	Have you ever had this, or a similar condition, in the past?	YES ☐ NO ☐
B	If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics	Condition(s): Dates:

3. A	Give exact date when injury occurred.	A	Date:
B	When did you first consult a Physician for this condition?	B	Date:
C	When did you become totally disabled (unable to work)?	C	Date:
D	When were you able to again perform part of your occupational duties?	D	Date:
E	When were you able to again perform all of your occupational duties?	E	Date:
F	If still totally disabled, when do you expect your disability to terminate?	F	Date:

4.	Hospitals (Give completed names, addresses and dates of confinement.)	NAMES	ADDRESSES	FROM TO
5. A	Give names, addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE
B	Give names, addresses and telephone numbers of usual family physicians.	NAMES	ADDRESSES	TELEPHONE
6.	Do you have any benefits under any other insurance plan including your spouse or guardian?	NAMES	ADDRESSES	BENEFITS
7.	What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics.)			
8.	Names and Addresses of Employers and length of employment with each?	NAMES	ADDRESSES	FROM TO

Approved By: **Date:**

Authorized Member's Signature

SIGNATURE OF CLAIMANT OR CLAIMANT'S PARENT/GUARDIAN

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CERTIFICATION OF TEAM MANAGER/ ASSOCIATION OR CLUB EXECUTIVE

Name of Team/ League/ Association _____

Was the Player a member at the time of accident?	☐ Yes	☐ No
Did the Injury occur during a sanctioned game or practice?	☐ Yes	☐ No
Is the player a member of the National Team?	☐ Yes	☐ No
Is the player an official or referee?	☐ Yes	☐ No

Name _____ Position _____

Signature _____ Phone Number _____

Date _____

Please attach the incident report.

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CLAIMANT AUTHORIZATION

I, _____ **, authorize** _____ **to release information**
(claimant name) (hospital name)
to Everest Insurance Company of Canada including:

- Admission History
- Lab Reports
- X-Ray/CT/MRI Reports
- Outpatient Records
- Ambulance Report
- Diagnostic Tests
- Discharge Summary
- Practitioner Notes
- Emergency Report
- Consultation Notes
- Inpatient Records
- Homecare Plans

Claimant (Patient):	
Date of Birth:	
Health Card Number:	
Admission Dates:	

The claimant acknowledges that this information is to be used by the Insurer named herein for the purpose of determining injuries as a result of the incident on the date of loss shown herein and to assist in evaluation of any related claims.

Any personal information collected will be protected in accordance with the *Personal Information Protection and Electronic Documents Act*. **Everest Insurance Company of Canada's Privacy Policy is available at www.everestcanada.com**

_____
Print Name of Claimant/ Guardian

_____ _____
Claimant/ Guardian Signature **Witness Signature**

_____ _____
Date **Date**

_____
Relationship if Signed by other than Claimant

This form is valid for one year from date of signature.
This form permits the release of hospital records from a hospital to the insurer.

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ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

ACCIDENT

PATIENT'S NAME AND ADDRESS	AGE

1 A	Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location.)	
B	Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain.	Yes ☐ No ☐
2 A	When did symptoms first appear or accident happen?	Date _____ Year: _____
B	When did patient first consult you for this condition?	Date _____ Year: _____
C	Has patient ever had same or similar condition? If "Yes" state when and describe.	Yes ☐ No ☐
3 A	Nature of surgical procedure, if any (describe fully).	Date performed _____ Year: _____
B	Charge to patient for this procedure including post-operative care.	$ _____
C	If performed in hospital, give name of hospital.	_____ Inpatient ☐ Outpatient ☐
4	Give dates of other medical (non-surgical) treatment, if any.	Office _____ Home _____ Hospital _____ Nursing Home _____
5	What other services, if any, did you provide patient? (Itemize, giving dates and fees)	
6	Were registered private duty nurse (R.N.) services necessary?	
7	Is patient still under your care for this condition? If "No" give date your services terminated.	Yes ☐ No ☐ Date _____ Year: _____
8 A	How long was or will patient be continuously totally disabled? (Unable to work?)	From _____ Year:____ Thru _____ Year:____
B	How long was or will patient be partially disabled?	From _____ Year:____ Thru _____ Year:____
C	Was house confinement necessary? If "Yes" give dates.	Yes ☐ No ☐ From _____ Year:____ Thru _____ Year:____
9	To your knowledge, does patient have other health insurance or health plan coverages? If "Yes" identify.	Yes ☐ No ☐

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	**CITY OR TOWN**	**PROVINCE**	**POSTAL CODE**