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K&K Insurance Brokers, Inc. Canada

ATHLETE ACCIDENT CLAIM FORM

File your claim promptly. Failure to do so could result in a denial of coverage. Consult the policy for the time limits for reporting and filing a claim.

SECTION I TO BE COMPLETED BY CLAIMANT'S AND/OR PARENT(S)/GUARDIAN(S)

1. Name: Last: _____ First: _____ Init: _____
2. Date of birth: _____ Sex: ☐ Male ☐ Female
3. Home Address: Street: _____
City: _____ Prov.: _____ Postal Code: _____
Parent's phone number: _____ Claimant's phone number: _____
4. Date of accident: _____ Time of accident: _____ ☐ AM ☐ PM
Nature of injury: _____ Describe exactly how accident happened: _____

5. Nature of activity during which the injury occurred (check all boxes which apply): ☐ Left ☐ Right
Name of sport, if applicable: _____

<input type="checkbox"/> Intercollegiate sports	<input type="checkbox"/> Intramural sports	<input type="checkbox"/> During practice
<input type="checkbox"/> Club sports	<input type="checkbox"/> High school catastrophic	<input type="checkbox"/> During play
<input type="checkbox"/> Other activity (specify) _____	<input type="checkbox"/> During conditioning	<input type="checkbox"/> During travel to or from the event

Nature of Your Participation:
☐ Student ☐ Athletic participant ☐ Other (specify) _____
6. Student? ☐ Yes ☐ No If yes, please identify the school name: _____
7. Name, address and phone of physician who first treated you: _____

8. Have you had a similar injury in the past? ☐ Yes ☐ No If yes, describe and give dates: _____

9. Name, address and phone of physician who treated you for previous injury: _____

10. Are you covered by any other medical expense benefits plan? ☐ Yes ☐ No If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you: _____

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief, the information contained is complete and correct as herein given.

I understand that it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s). See remarks section on reverse side of this form.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance Group Canada, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant/Parent/Guardian Signature _____

COMPLETE AND FORWARD TO K&K INSURANCE

SECTION II**TO BE COMPLETED BY THE INSURED**

1. Name of claimant: Last: _____ First: _____ MI: _____
2. Insured location: _____ 3. Date of accident: _____
4. Sport: Volleyball
5. Nature of injury: _____ 6. ☐ Left ☐ Right
7. Name of Club: Canadian Volleyball Association
8. Name of provincial athletic association if applicable: _____
9. If this injury was a reinjury, was the athlete cleared to participate? ☐ Yes ☐ No
10. IF YES, please attach physician's statement indicating doctor's release to return to athletic participation.
11. I certify that all the foregoing statements and answers on this form are true and complete, and that this claim satisfies all criteria set forth in our ACCIDENT POLICY for proper consideration as a covered participant, covered activity and a covered condition, to the best of my knowledge and belief.
- Signature of Authorized Representative: _____
- Title: _____ Date: _____
- Comments: _____

FAILURE TO COMPLETE THIS FORM IN FULL MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM

COMPLETE AND FORWARD TO K&K INSURANCE

**INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM
TO THE INJURED PERSON/PARENT /GUARDIAN**

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.

K&K INSURANCE GROUP CANADA

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