



SPORT ACCIDENT CLAIM 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) _____

Home Phone _____ Daytime Phone Number: _____

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? Yes or No

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 _____



PHYSICIAN'S STATEMENT

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician 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 _____



ACCIDENT CLAIM FORM INSTRUCTIONS

⇒ Please submit your completed form to Softball Ontario at info@softballontario.ca