

Note: Please do not submit claims for medical expenses covered under a Government or any other Health Plan. Your claim may be rejected if any part of this form is incomplete or incorrect.

MAIL TO: Softball B.C.
P.O. Box 45570
Sunnyside Mall
Surrey, B.C.
V4A 9N3

INSURANCE CLAIM FORM

SECTION I

Full Name of Insured _____ Birthdate _____

Mailing Address _____

City _____ Province _____ Postal Code _____

If a Minor, Name of Parent _____

Home Phone _____ Business Phone _____

SECTION II

Date of accident _____ 19 ____ Hour _____ a.m./p.m.

Location of accident _____

What is the injury _____

Name of hospital taken to _____

Date of admittance _____ 19 ____ Hour _____ a.m./p.m.

Date of discharge _____ 19 ____ Hour _____ a.m./p.m.

Attending Physician or Dentist's name _____

Address of Physician or Dentist _____

_____ Date of first treatment _____

SECTION III

Describe fully how the accident occurred _____

SECTION IV

What medical coverage do you have through your employment (if a Minor, through parent's employment)?

Name of Company or Institution _____

Address _____

Policy No. _____ Certificate No. _____

Date _____ Signature _____

Certificate of Association or Club Executive

(Do not complete this section yourself. Have your Club or League President, Coach or Manager complete this.)

Name of Team	League or Association	Group Policy No.
_____	_____	ASIM 1035
Was the above player a Registered Member at the time of injury? Yes ___ No ___	On what date did the Insured join the team or Association? _____	Name of Sport _____
Was Player injured while taking part in practice or activity? Yes ___ No ___	_____	An Authorized League Game? Yes ___ No ___

Name Position with Club _____

Address _____

Telephone No. _____ Signature _____

(See instructions on reverse side.)

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated: _____

If hospitalized, give name of hospital: _____

Date Admitted: _____ 19 _____ Discharged: _____ 19 _____

If referred to you, give name of referring physician: _____

Operations (or other procedures) performed:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ 19 _____ Date of Accident: _____ 19 _____

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? _____

Date: _____ 19 _____ Signature _____ (M.D.)

Address: _____

Certified Specialist: _____

Phone: _____