

SAFETY REQUIRES TEAMWORK

Available for download at: www.hockeycanada.ca/insurance



HOCKEY CANADA INJURY REPORT

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See reverse for mailing address
Forms must be filled out in full or form will be returned. This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. DATE OF INJURY: ___/___/___
Mo. Day Yr.

INJURED PARTICIPANT: Player Team Official Game Official Spectator

Name: _____ Birthdate: ___/___/___ Sex: M F
Mo. Day Yr.

Address: _____

City / Town: _____ Province: _____ Postal Code: _____ Phone: (____) _____

Parent / Guardian: _____ Email Address: _____

DIVISION <input type="checkbox"/> Initiation <input type="checkbox"/> Novice <input type="checkbox"/> Atom <input type="checkbox"/> Peewee <input type="checkbox"/> Bantam <input type="checkbox"/> Midget <input type="checkbox"/> Juvenile <input type="checkbox"/> Junior	CATEGORY <input type="checkbox"/> AAA <input type="checkbox"/> A <input type="checkbox"/> BB <input type="checkbox"/> CC <input type="checkbox"/> DD <input type="checkbox"/> House <input type="checkbox"/> Minor Junior <input type="checkbox"/> Adult Rec. <input type="checkbox"/> AA <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> Major Junior <input type="checkbox"/> Senior <input type="checkbox"/> Other _____
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BODY PART INJURED <table border="1"> <tr> <td> Head <input type="checkbox"/> Face <input type="checkbox"/> Skull <input type="checkbox"/> Eye Area <input type="checkbox"/> Throat <input type="checkbox"/> Dental </td> <td> Back <input type="checkbox"/> Lower <input type="checkbox"/> Neck <input type="checkbox"/> Upper </td> <td> Trunk <input type="checkbox"/> Abdomen <input type="checkbox"/> Ribs <input type="checkbox"/> Chest </td> </tr> <tr> <td> Arm: <input type="checkbox"/> Left <input type="checkbox"/> Collarbone <input type="checkbox"/> Right <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Upper arm <input type="checkbox"/> Forearm/Wrist </td> <td> Leg: <input type="checkbox"/> Left <input type="checkbox"/> Knee <input type="checkbox"/> Right <input type="checkbox"/> Toe <input type="checkbox"/> Shin <input type="checkbox"/> Thigh <input type="checkbox"/> Other <input type="checkbox"/> Foot </td> <td> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Groin </td> </tr> </table>	Head <input type="checkbox"/> Face <input type="checkbox"/> Skull <input type="checkbox"/> Eye Area <input type="checkbox"/> Throat <input type="checkbox"/> Dental	Back <input type="checkbox"/> Lower <input type="checkbox"/> Neck <input type="checkbox"/> Upper	Trunk <input type="checkbox"/> Abdomen <input type="checkbox"/> Ribs <input type="checkbox"/> Chest	Arm: <input type="checkbox"/> Left <input type="checkbox"/> Collarbone <input type="checkbox"/> Right <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Upper arm <input type="checkbox"/> Forearm/Wrist	Leg: <input type="checkbox"/> Left <input type="checkbox"/> Knee <input type="checkbox"/> Right <input type="checkbox"/> Toe <input type="checkbox"/> Shin <input type="checkbox"/> Thigh <input type="checkbox"/> Other <input type="checkbox"/> Foot	Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Groin	NATURE OF CONDITION <input type="checkbox"/> Concussion <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Contusion <input type="checkbox"/> Dislocation <input type="checkbox"/> Separation <input type="checkbox"/> Internal Organ Injury
Head <input type="checkbox"/> Face <input type="checkbox"/> Skull <input type="checkbox"/> Eye Area <input type="checkbox"/> Throat <input type="checkbox"/> Dental	Back <input type="checkbox"/> Lower <input type="checkbox"/> Neck <input type="checkbox"/> Upper	Trunk <input type="checkbox"/> Abdomen <input type="checkbox"/> Ribs <input type="checkbox"/> Chest					
Arm: <input type="checkbox"/> Left <input type="checkbox"/> Collarbone <input type="checkbox"/> Right <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Upper arm <input type="checkbox"/> Forearm/Wrist	Leg: <input type="checkbox"/> Left <input type="checkbox"/> Knee <input type="checkbox"/> Right <input type="checkbox"/> Toe <input type="checkbox"/> Shin <input type="checkbox"/> Thigh <input type="checkbox"/> Other <input type="checkbox"/> Foot	Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Groin					

INJURY CONDITIONS Name of arena / location: _____ <input type="checkbox"/> Exhibition/Regular Season <input type="checkbox"/> Period #2 <input type="checkbox"/> Playoffs/Tournament <input type="checkbox"/> Period #3 <input type="checkbox"/> Practice <input type="checkbox"/> Overtime: _____ <input type="checkbox"/> Try-outs <input type="checkbox"/> Dry Land Training <input type="checkbox"/> Other <input type="checkbox"/> Gradual Onset <input type="checkbox"/> Warm-up <input type="checkbox"/> Other Sport <input type="checkbox"/> Period #1 <input type="checkbox"/> Other: _____	CAUSE OF INJURY <input type="checkbox"/> Hit by Puck <input type="checkbox"/> Collision with Boards <input type="checkbox"/> Non-Contact Injury <input type="checkbox"/> Hit by Stick <input type="checkbox"/> Collision on Open Ice <input type="checkbox"/> Collision with Opponent <input type="checkbox"/> Fall on Ice <input type="checkbox"/> Checked from Behind <input type="checkbox"/> Collision with Net <input type="checkbox"/> Fight <input type="checkbox"/> Blindsiding	Was the injured player in the correct league and level for their age group? <input type="checkbox"/> Yes <input type="checkbox"/> No Was this a sanctioned Hockey Canada activity? <input type="checkbox"/> Yes <input type="checkbox"/> No
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WEARING WHEN INJURED <input type="checkbox"/> Full Face Mask <input type="checkbox"/> Intra-Oral Mouth Guard <input type="checkbox"/> Half Face Shield/Visor <input type="checkbox"/> Throat Protector <input type="checkbox"/> Helmet/No Face Shield <input type="checkbox"/> No Helmet/No Face Shield <input type="checkbox"/> Short Gloves <input type="checkbox"/> Long Gloves	ADDITIONAL INFORMATION Has the player sustained this injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" how long ago _____ Was a penalty called as a result of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated absence from hockey? <input type="checkbox"/> 1 week <input type="checkbox"/> 1-3 weeks <input type="checkbox"/> 3+ weeks	DESCRIBE HOW ACCIDENT HAPPENED (Attach page if necessary) _____ _____ _____ _____ _____	I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photo static/electronic copy of this authorization shall be considered as effective and valid as the original. Signed: _____ (Parent/Guardian if under 18 years of age) Date: _____
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TEAM INFORMATION (To be completed by a Team Official) Association: _____ Team Name: _____ Team Official (Print): _____ Team Official Position: _____ Signature: _____ Date: _____	HEALTH INSURANCE INFORMATION THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED Occupation: <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Full-Time Student Employer (If minor, list parent's employer): _____ 1. Do you have provincial health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Province: _____ 2. Do you have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.) 3. Has a claim been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.) Make Claim Payable To: <input type="checkbox"/> Injured Person <input type="checkbox"/> Parent <input type="checkbox"/> Team <input type="checkbox"/> Other: _____	Member APPROVAL
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PHYSICIAN'S STATEMENT

Physician: _____ Address: _____ Tel: (____) _____

Name of Hospital / Clinic: _____ Address: _____

Nature of Injury: _____ Date of First Attendance: _____

_____ Claimant will be totally disabled:

_____ From: _____ To: _____

_____ Is the injury permanent and irrecoverable? No Yes

Give the details of injury (degree): _____

Prognosis for recovery: _____

Did any disease or previous injury contribute to the current injury? No Yes (describe): _____

Was the claimant hospitalized? No Yes (give hospital name, address and date admitted): _____

Names and addresses of other physicians or surgeons, if any, who attended claimant: _____

I certify that the above information is correct and to the best of my knowledge,

Signed: _____ Date: _____

DENTIST STATEMENT

Limits of coverage: \$1,250 per tooth, \$3,000 per accident. Treatment must be completed within 52 weeks of accident. (Effective September 1st, 2018)

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

Patient

Last name Given name

Address

City / Town Province Postal Code

Dentist

PHONE NO _____

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER

SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.

DUPLICATE FORM

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR THE SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF (PATIENT/GUARDIAN) OFFICE VERIFICATION

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE. TOTAL FEE SUBMITTED

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

Mail completed form to: **HOCKEY CANADA** Tel: 613-696-0211
 c/o House of Sport, RA Centre Fax: 613-696-0787
 2451 Riverside Drive Ottawa, ON K1H 7X7 www.hockeycanada.ca