ACCIDENT INSURANCE CLAIM FORM

Return to : Softball Québec
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OR
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Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

Please follow these instructions:

1. **PART A** - This section must be completed, in full and signed by the insured. If insured is under age 18, this section must be completed by the Parent or Guardian. If claim is for Accident Expense Reimbursement and/or fracture benefit, enclose original expenses and have PART B - Physician's Statement completed.
2. **PART B** - This section is to be completed and signed by physician (any costs incurred for the completion of this form are the insured's responsibility. When applicable, may differ per policy).
3. **PART C** - This section is to be completed by your dentist if your claim is for dental accident expenses.

Please ensure that original claim documents and invoices are submitted

PART A – CLAIMANT STATEMENT

Policy No.: SG30107626			
1.	Name of Insured: Last Name:	First Name:	
	If insured is under age 18, name of Parent/Guardian: Last Name:		First Name:
2.	Address:		
	City:	Province:	Postal Code:
	Phone #: ( )		
	Email Address:		
3.	Date of Accident: Month:	Day:	Year:
	Time:	☐ AM ☐ PM	
	Date of Birth: Month:	Day:	Year:
4.	Place of Accident:		
5.	Please explain in detail how the accident happened:		
6.	Describe The Injury:		
7.	Are you covered by another Insurance Company for benefits? ☐ Yes ☐ No		
	If so, please provide the company name and provide your policy number.		
	Company:	Indemnity:	

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

Authorization: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim. I agree that a photocopy of this authorization shall be as valid as the original.

Insured/Insured's Parent/Guardian Signature

Date (DD/MM/YYYY)

PART B – ATTENDING PHYSICIAN'S STATEMENT

The patient is financially responsible for the completion of the form.

Physician's Name (Print)		**Patient's Name (Print)**	
Name:		Name:	
Address:		Address:	
City:		City:	
Province:	Postal Code:	Province:	Postal Code:
Phone #: ( )		Phone #: ( )	

Diagnosis including complications (If fracture, specify bone and type of fracture, provide x-ray report) and Nature of Injury:
Is condition due to an accident? ☐ Yes ☐ No
a. Symptoms first appeared or accident happened (mm/dd/yy):
b. Patient has had same or similar condition: ☐ No ☐ Yes If yes, when and describe:
Was claimant hospitalized? ☐ No ☐ Yes If yes, provide the following information:

Name of Hospital:	Date Admitted (DD/MM/YYYY):	
Hospital Address:		
City:	Province:	Postal Code:
Date of First Visit for present period of disability (DD/MM/YYYY):		
Date of last attendance (DD/MM/YYYY):		
Date of next scheduled follow up appointment (DD/MM/YYYY):		
Please outline the treatment plan recommended and prescribed:		
Names and addresses of other physicians or surgeons, if any, who attended claimant:		

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

M.D.

Signature ____________________ Date (DD/MM/YYYY) ____________________

Address:		
City:	Province:	Postal Code:
Phone #: ( )		

PART C – ATTENDING DENTIST'S STATEMENT

Please provide the following documentation: Standard Dental claim form for dental services provided, including the dates of service, tooth and procedure codes and fees incurred OR dental estimate.

Is treatment required as the result of an accident? ☐ Yes ☐ No

This is an accurate statement of services performed, and fees charged.

For dentist's use only, for additional information re: Diagnosis, procedures or complications and special considerations:

Dentist's Signature	Date (DD/MM/YYYY)

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of my treatment. I authorize release of the information contained in this claim form to my insuring company or its agents. I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Insured/Insured's Parent/Guardian Signature	Date (DD/MM/YYYY)