

Attention: Hala Chadi hchadi@albertasoccer.com

AIG	
AIG Insurance Co	
120 Bremner Boule	evard, Suite 2200
Toronto, ON M5J	0A8

## **ACCIDENT CLAIM FORM**

**IMPORTANT:** The form must be validated by your Association (on the Association Statement on the last page of this form) & may be returned by email at hchadi@albertasoccer.com

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1.	<ul><li>a)</li><li>b)</li><li>c)</li><li>e)</li><li>f)</li></ul>	Full name of Insured: Address: Phone number: d) Date of Birth (MM/DD/YY): Email: If the Claimant is a minor child, Name of Parent/Guardian: NOTE: If the Claimant is a minor child, the Parent/Guardian must sign this form			
2.	Nar	ame of the Association:			
3.	a) c) d) e)	Date of accident (MM/DD/YY):  Circumstances: Injury: Date of first medical attention (MM/DD/YY):			
4.	a)	Do you have a Group Insurance (through work, etc.) that covers paramedical expenses (Ambulance, Physiotherapy, etc.)? $\square$ YES $\square$ NO			
	b)	If yes, name of Insurance Company:  NOTE: You must first submit your expenses through your Group Insurance and then provide us with a copy of the Explanation of benefit and a copy of your receipts			
5.	Nar	Name and address of Physician who treated you for this condition:			
6.	a) b)	Did the injury require Hospitalization? ☐ YES ☐ NO  If yes, hospitalization dates: from (MM/DD/YY): to (MM/DD/YY):			
	c)	Name of Hospital:			
Insure determine also infor CER and payre claim AUT care composte with AIG any	rance ( rmining consultation of the consultati	LINFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to g if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will lit its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange in with, third parties.  ATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge 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 recovered. 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 payments. 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 fer, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any protein or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange is urance Company of Canada.  Ince Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be the original.			
Na	me o	of Insured's Parent/Guardian (if under age 18 - print please):			
_		re of Insured or Insured's Parent/Guardian (if under age 18): IM/DD/YY):			

## **PHYSICIAN'S STATEMENT**

1.	Name of Patient:				
2.	Dia	iagnosis / Injury:			
3.	a) b) c)		] NO		
	d)	Date of first attendance (MM/DDY/Y):			
4.	Re	ecommended treatments:			
5.	a)	Was the patient hospitalized: ☐ YES ☐ NO			
	b)	If yes, please provide name of hospital and dates:			
		These statements are true and complete to the best of	f my knowledge and belief.		
Name of Attending Physician (please print):					
Address:					
Signature of Attending Physician:			ate (MM/DD/YY):		
Phone Number:		Number: Fa	ax Number:		

## **ASSOCIATION STATEMENT**

	The furnishing of forms shall not be an admission of liability by the Company.				
Title	e: Phone Number: Email:				
Sig	nature: Date (MM/DD/YY):				
Please attach a copy of your incident report related to this event (if available).					
5.	Did the injury occur while the person was participating in an activity approved by the Association? $\square$ YES $\square$ NO				
4.	Was the person a member or volunteer at the time of the accident? $\ \square$ YES $\ \square$ NO				
3.	The injured person is: ☐ Member ☐ Volunteer				
2.	<ul><li>a) Name of Association:</li><li>b) Name of Club / Team:</li></ul>				
1.	Name of Injured person:				