Accidental Injury
The Canadian Ball Hockey Association

HOW TO FILE A CLAIM

1. **Complete all items on the attached claim form.**

2. **Attach the following documents (as applicable):**

   - **Fully completed Claimant & Attending Physician Statement (Required for all claims)**
   - **Copies of Game Sheets, Game Reports, or any Referee Reports**
   - **Copies of all police reports (if applicable)**
   - **Copies of any additional documents that support your claim**

3. **Send the completed and signed claim form and all required documents to:**

CANADIAN BALL HOCKEY ASSOCIATION
8661 – 201st STREET, 2nd FLOOR,
LANGLEY, BC V2Y 0G9

OR

FAX: 1-866-203-0044
EMAIL: ADMIN@CBHA.COM

4. **Retain a copy for your records.**

YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE CALL DIANE CLOUTIER AT 1-866-688-9888

Accidental Injury Claim

The Canadian Ball Hockey Association

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

Policy # 9906 00 76

INSURED INFORMATION

Insured's Name _____ **Date of Birth** ___/___/___ **Marital Status** _____

Insured's Address _____ **Phone No. (H)** _____

_____ **Phone No. (W)** _____

Insured's Team Name _____ **League Name** _____

Did the insured have any other insurance, including employee health plans? _____ **If yes, please list all companies, type of insurance, policy numbers and insurance amounts:** _____

_____

CLAIM INFORMATION

Date of accident ____/_____/_____ **Time and place accident occurred** _____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Did the accident occur during a game? _____ **If so, how?** _____

Please describe the nature of Insured's injuries: _____

Please list the names and addresses of all treating physicians and hospitals: _____

_____

_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

VERIFICATION OF ACCIDENT

Name of Referee verifying accident _____ **#** _____ **Referee's signature** _____

Name of League Director verifying accident _____ **Director's signature** _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____ **DATE** ____/____/____

CBHA OFFICE USE ONLY

Date claim received _____/____/____ **Date claim processed** _____/____/____

Approved by _____ **CBHA rep signature** _____ **Date** ____/____/____

CHUBB

Accidental Injury Claim

Attending Physician's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **Soc. Sec. No.** _____-____-_____ **Date of Birth** ____/___/___ **Marital Status** _____

Insured's Address_____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Name and address of employer _____

Policy Number (Required)_____ **Insured's Occupation** _____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries, including all applicable ICD-9-CM codes:

_____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Was the Insured hospitalized? _____ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**

_____

_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe: _____

_____

Were any surgical procedures performed? _____**If yes, please list all procedures, including applicable CPT4 codes and dates performed:**

_____

_____

What are the Insured's current subjective symptoms? _____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? _____

_____

Dates of total disability: **Dates of partial disability:**

From: _____/_____/_____ **through:** _____/____/____ **From:** _____/_____/_____ **through:** _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? _____**If yes, please list the names and addresses of all other physicians:** _____

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____**Phone No.** _____

Address: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____**DATE** ____/____/____