The Citadel Assurance

the citadel
2001 University st, suite 1850
Montreal Quebec H3A 2L8

Proof of Loss – Accidental Injury – Sport Insurance

Instructions
Injured member complete Injury Section.
Attending Physician complete Physician Section.
Team Manager or Administrator complete Club Section.

Note
If injury involves teeth, please complete Accidental Dental Claim Form.
Attach original medical bills to completed form and return to The Citadel Assurance

If the member is covered under any other Medical insurance plan, the expenses must be submitted to that plan.
If there is any unpaid balance, please attach their Payment Statement.

Please **print** or **type** all your answers.

Insured Statement Section (to be completed by injured member)

1. Full Name of Insured Person ____________________
2. Date of Birth D M Y ____________
3. If a Minor, give Full Name of Parent or Guardian ____________
4. What is your occupation outside of your sports activities? ____________
5. Employer ____________
   Address ____________
   Street City Province Postal Code
6. Name of Team for which you were playing ____________
7. Type of Sport ____________
8. Date of Accident D M Y ____________
9. Date first treated by doctor D M Y ____________
10. Where did accident occur? ____________
11. Full Name of Physician who first treated you ____________
    Address ____________
    Street City Province Postal Code
12. Describe injury ____________
13. Describe fully how accident occurred ____________
14. Full Name(s) of other doctor(s) who treated you ____________
15. Was it during an approved practice, game or travelling? ☐ Yes ☐ No
16. Do you have any other Hospital or Medical Insurance? ☐ Yes ☐ No Plan Name/Policy Number ____________

I certify to the best of my knowledge that the statements made above are true, correct and complete.

____________ ( ) ____________ D M Y ____________
Injured Member's Signature (or Signature of Parent or Guardian if injured member is a minor) Telephone Date

Complete Address ____________
Street City Province Postal Code

Certificate of Team Manager or Administrator

1. Name of Team ____________
2. Policy Number **9207251**
3. Name of League or Association ____________
4. What sport is team engaged in ____________
5. On what date did player join the team D M Y ____________
6. Was the above player a regular member at the time of injury ☐ Yes ☐ No
7. Was the player injured during an approved activity? ☐ Yes ☐ No

____________ ____________ ____________
Authorized Signature Print Name Official Position/Title

Complete Address ____________
Street City Province Postal Code

Telephone ( ) ____________ Date D M Y ____________

Attending Physician Statement Section

1. Patient's Name ______ 2. Patient's Age ______

3. Diagnosis of present condition ______
   (a) Primary ______
   (b) Secondary (if applicable) ______

4. On what dates did you examine the patient? D M Y ______ | D M Y ______ | D M Y ______

5. To the best of my knowledge
   (a) Symptoms first appeared or accident happened D M Y ______
   (b) Patient has had same or similar condition? ☐ Yes ☐ No
   If "Yes", state particulars ______

6. If taken to hospital, name of hospital ______
   Admitted D M Y ______ Time ______ AM/PM
   Discharged D M Y ______ Time ______ AM/PM

7. If surgery performed, describe ______

8. If patient referred to you, give name of referring physician ______

9. Have you referred the patient to a specialist for additional treatments? ☐ Yes ☐ No
   If "Yes", please explain ______

Physician's Name (Print) ______ Physician's Signature ______

Address ______
Street City Province Postal Code

Telephone ( ) ______ Date D M Y ______

I hereby authorize the release to my Insurer and my Policyholder of any information requested in respect of the claim.

Signature of Patient ______ Date D M Y ______

The patient is responsible for securing the form and for charges made for its completion.