

# Proof of Loss – Accidental Dental (Sports Insurance)



**Please answer all questions fully – it helps us to provide better service**

**Instructions** - Insured member - complete Claimant's Statement; Team Manager or Administrator - complete Club Section at bottom of page 1. Attending Dentist - complete Dental Section on page 2.

**Important** - If the member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to the Dental plan. If there is any unpaid balance, please attached their payment statement(s).

**Note** – This form can be completed in ink (please print), however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned to **AXA Assurances Inc.** at the following address:

**2020 University Street, Suite 700, Montreal, Quebec H3A 25A**

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

## Claimant's Statement

**Policy Number** 9207251

1. Insured Member's Full Name \_\_\_\_\_

2. Date of Birth D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

3. If a minor, give full name of parent or guardian \_\_\_\_\_

4. What is your occupation outside your sports activities? \_\_\_\_\_

5. Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

Number & 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. Where did accident occur? \_\_\_\_\_

10. Describe in detail how accident occurred \_\_\_\_\_

11. Was it during an approved:  practice  game  travelling

12. Where was practice or game taking place? \_\_\_\_\_

13. Date first treated by dentist D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

14. Name of Dentist \_\_\_\_\_

Address \_\_\_\_\_

Number & Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

15. Name(s) of other dentist(s) who treated you \_\_\_\_\_

16. If treated in hospital, Name of Hospital \_\_\_\_\_

17. Date treated D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

18. Do you have coverage for any dental expenses under any other Hospital, Medical or Dental Plan?  Yes  No

If Yes, Plan Name \_\_\_\_\_ Company \_\_\_\_\_ Policy Number \_\_\_\_\_

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

\_\_\_\_\_  
Claimant's Signature (or signature of Parent or Guardian if Claimant is a minor)

( \_\_\_\_\_ )  
Telephone Number

\_\_\_\_\_  
Date

Complete Address \_\_\_\_\_

Number & Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

*The furnishing of this form or its acceptance is not an admission of liability by the company or a waiver of any conditions of the policy.*

## Club Section

**Policy Number** 9207251

1. Name of Team \_\_\_\_\_

2. Name of League or Association \_\_\_\_\_

3. What sport is team engaged in? \_\_\_\_\_

4. What date did player join team D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

5. Was the player a regular member at time of injury?  Yes  No

6. Was the player injured doing an approved activity?  Yes  No If Yes, an approved  practice  game  travelling

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Official Position/Title

Complete Address \_\_\_\_\_

Number & Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

\_\_\_\_\_  
Date D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

