

<b>SECTION I (please print)</b>		
Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone ( )	Business Phone ( )	


<b>SECTION II</b>		
Date of Accident	Hour	a.m./p.m.
Location of the Accident		
What is the Injury?		
Date of First Treatment		
Name of Hospital taken to		
Date of Admittance	Hour	a.m./p.m.
Date of Discharge	Attending Physician or Dentist	

<b>SECTION III</b>	Describe fully how the accident happened.

<b>SECTION IV</b> (your sports accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses) <b>What medical coverage do you have through your Provincial Health Care /spouse/parent employment?</b>				
Name of Employer	Name of Insurer			
Address of Employer	Address			
City	Prov.	Postal Code	Policy No.	Certificate

<b>SECTION V</b>	
Name of Provincial Club	Name of Members Club
Type of Event:	Event Category

<b>SECTION VI</b>	
I hereby certify that all the information provided above is correct.	
Claimant's / Guardian Signature	Date

<b>SECTION VII</b> (To be completed by Provincial Association)*	
This is to certify that	member of Canada-Snowboard
Officer of Provincial Association	Date
	

*\*personnel authorized to confirm an individual membership in a program and signed confirmation that a loss was suffered while an individual was participating/training in a SPNI program, tour or competition)*

Send completed form along with any invoices for expenses you had to pay yourself to:

**Maxwell Claims Services Inc.:**

**Claims contact: Ryan Gussak ([ryan@maxwellcalgary.com](mailto:ryan@maxwellcalgary.com))**

**Maxwell Claims Services Inc., #101, 1400 – 1<sup>st</sup> Street S.W., Calgary, AB T2R 0V8**

**Local Telephone: 1 (403) 699-8510, Toll Free: 1 (403) 699-8510, Fax: (403) 699-8558**

Please complete this claim form and return it to your patient.

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

\_\_\_\_\_  
\_\_\_\_\_

Prescribed Treatment(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If hospitalized, give name of hospital: \_\_\_\_\_

Date Admitted: \_\_\_\_\_ Discharged: \_\_\_\_\_

If referred to you, give name of referring physician:

\_\_\_\_\_

Operations (or other procedures performed):

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Date of first consultation for above: \_\_\_\_\_

Date of first symptoms: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Has the patient ever had same or similar condition? \_\_\_\_\_

If "Yes", please state when and describe:

\_\_\_\_\_  
\_\_\_\_\_

Is there any other disease or infirmity affecting the present condition?

\_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(M.D.)

Address:

\_\_\_\_\_

Certified Specialist:

\_\_\_\_\_

Phone: \_\_\_\_\_

