

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

SECTION II	
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

SECTION III Describe fully how the accident happened.

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

SECTION V	
Name of Provincial Club	Name of Members Club
Type of Event:	Event Category

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

SECTION VII (To be completed by Provincial Association)*	
This is to certify that member of .	
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:

Claimspro :
E-Mail for new claims or questions: jbelaims@scm.ca
Claims contact : Carolyn Duncan (carolyn.duncan@scm.ca)
SCM Insurance Services, Suite 2401, 120 Adelaide St West
Toronto, ON M5H 1T1 Telephone : (888)204-4726 Ext : 308 FAX : (416)360-7335

ATTENDING PHYSICIAN'S STATEMENT

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: _____

