Please submit this form to:
Skate Canada
865 Shefford Road Ottawa, ON K1J 1H9
E-mail: safesport@skatecanada.ca
Fax: 613-748-5718 Toll Free Fax:1-877-211-2372
Phone: 613-747-1007 Toll Free: 1-888-747-2372

CLAIMANT'S STATEMENT - PLEASE PRINT
Policy number: SRG 9021042A

Claimant's Surname _____ Claimant's Given Name: _____

Address _____

Email _____ Telephone No.: _____

City/Town _____ Province _____ Postal Code _____

Date of Birth: D / M / Y _____ Sex: ☐ Male ☐ Female

1. Date of Accident: _____ Date of Initial Medical attention: _____
2. Name of your sports club or leisure: _____
3. Name of your provincial association / federation: _____
4. Full Details of Accident: _____
5. What injuries were sustained? _____
6. Name and Address of Family Physician: _____
7. Name and address of witness to this accident: _____
8. Name and Address of Surgeons or Specialists who provided treatment regarding this accident:
_____
9. Please provide term of totally disability which prevented you from engaging in your pre-accident occupation (please attach supporting medical certification) From:_____ To:_____

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Skate Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. **CERTIFICATION**: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim. **AUTHORIZATION**: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with the insurance company, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be as valid as the original.

_____ _____
Signature of Insured or Insured's Parent/Guardian (if under age 18) Date

Please send claim form to SKATE CANADA within 15 days
**** PLEASE HAVE YOUR PHYSICIAN AND YOUR TEAM REPRESENTATIVE COMPLETE PAGE 2 OF THIS FORM. ****

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PHYSICIAN'S STATEMENT - PLEASE PRINT

Policy number: SRG 9021042A

Name of Patient: _____

Full description of injury sustained:_____

_____

Date of First Attendance: _____ Date of Actual loss: _____

Is loss permanent and irrecoverable? Give degree of loss _____

Was claimant hospitalized? ( ) No, and if ( ) Yes- Give Hospital name, address and date admitted.

_____

Is claim the direct result of an accident? ( ) No ( ) Yes

Did any disease or previous injury contribute to loss? ( ) No, and if ( ) Yes- Describe_____

_____

Name and address of other physicians or surgeons, if any, who attended claimant. _____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____MD Date: _____

Attending Physician's Name (please print): _____

Address: _____

Phone Number: _____ Fax Number: _____

ASSOCIATION STATEMENT FROM YOUR TEAM REPRESENTATIVE

Name of insured: _____ Insured's effective date:_____

Insured's classification (e.g. athlete, coach, participant, leader etc) _____

Did the injury occur while claimant was participating in a sanctioned event? ( ) No, ( ) Yes, please describe: _____

_____

Description of injury:_____

Please attach a copy of your incident report related to this event (if available)

Date :_____Signature:_____

Telephone: _____Title: _____