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SPORT ACCIDENT CLAIM FORM INSTRUCTIONS 2021

- Arthur J. Gallagher Canada Limited., must receive notification of your accident within 30 days of it occurring and receive your claim form within 90 days of the accident.
- Complete attached Sport Accident Claim Form and Physician Statement. If your claim is for dental injury have your dentist complete and submit a Predetermination Form.
- Forward original forms by mail to Arthur J. Gallagher Canada Limited. at 435 McNeilly Road, Suite 103, Stoney Creek Ontario L8E 5E3, along with a copy of expense receipts. Also, a copy should be sent to Canadian Cycling Association.
- If you intend to make a claim but have not had out of pocket expenses to date, complete and submit claim form indicating that receipts are to follow.
- If you have questions regarding submission of forms please contact Melissa LaRocca via email at Melissa_LaRocca@ajg.com

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Canadian Cycling Association – Sport Accident Claim

MEMBER INFORMATION

Full Name of Insured Person (member):_____

Membership # _____

Affiliated Club Name: _____

Date of Birth (mm/dd/yyyy) _____ Male ☐ Female ☐

Mailing Address Including City and Potal Code:

_____

Contact Person if Claiming is a minor (parent or guardian):

_____

Home Telephone:_____ Cell Phone: _____ Email: _____

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Name of Sanctioned Event or Activity:

_____

Describe in detail how the accident happened:

_____

Type of Injury:

_____

Name of Doctor/Dentist:

_____

Address of Doctor/Dentist:

_____

Do you have other benefits provided under any other insurance plan? ☐ Yes ☐ No (if "Yes", please provide name of Insurer and policy number (certificate):

_____

I Hereby certify that all information provided in this accident form is correct.

Claimant/Guardian Signature: _____ Date: _____

AFFILIATE INFORMATION

Name of Team/League Association:

_____

Was the player a member at the time of the accident?

_____

Was the injury during a sanctioned event or activity?

_____

SIGNATURE By signing this form you are consenting to the statements above.

Name (please print) _____ Title: _____

Signature: _____Date: _____

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Canadian Cycling Association – Physician's Statement

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician Statement.

Name of Patient: _____

Date of Birth (mm/dd/yyyy): _____ Male/ Female: _____

Mailing Address: Street: City: Postal Code:

_____

Date of first visit: _____

Complete description of the injury and your diagnoses: _____

_____

If hospital was required, give name of facility: _____

Date admitted: _____

Discharge date:_____

Name of referring physician, if any:

Physician Name: _____

Physician Address: _____

Physician Telephone: _____

_____ _____ _____

Physician Signature: RCPS ID # Date: