



INSTRUCTIONS

You must provide all information requested as follows:

IMPORTANT FACTORS TO CONSIDER WHEN COMPLETING YOUR CLAIM:

1. Your Insurer must receive the Notice of Accident within 30 days of the accident date, and receive claim documentation within 90 days.
 - date of treatments paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted
 2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
 - Patient's Name
 - Date of each purchase or service
 - Type of purchase or service
 - Amount charged for each purchase or service
 3. If you are claiming other than dental or ambulance expense, a physician statement confirming diagnosis and recommended treatments is required.
 4. Only claims in exceeding the deductible, as specified in your plan details, will be considered for payment up to your maximum benefits.
 5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.
- IF YOU ARE CLAIMING ANY OTHER BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:
(Please check you plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)
- FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE
- A. PRESCRIPTION DRUGS
 - name of medication or drug
 - date of purchase
 - amount charged
 - B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
 - physician referral
 - type of service
 - date of each treatment
 - amount charged for each treatment
 - C. HOSPITAL ROOM ACCOMODATION
 - not an eligible expense
 - D. EMERGENCY TRANSPORTATION
 - date of service
 - places taken from and to
 - amount charged
 - E. SCHEDULED FRACTURE INDEMNITY
 - if your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable.
 - a statement completed by the licensed physician or surgeon confirming the fracture/dislocation
 - F. MEDICAL BRACES
 - a letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed, must be submitted with your receipt
 - medical braces required primarily for sporting type activities are not covered
 - G. DENTAL ACCIDENTS
 - exact date of accident
 - breakdown of services performed
 - circumstances surrounding the accident
 - is there other dental coverage? Enclose details
 - confirmation that treatments only relate to the accident
 - provide other insurer's explanation
 - are further treatments estimated?
 - H. VISION CARE
 - if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
 - an explanation must be submitted with your receipt to claim the limited benefit
 - I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
 - your Accident Medical Policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not



ACCIDENT MEDICAL CLAIM FORM

SECTION I (please print)		
Claimant's Surname	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone	Business Phone	Cell phone
Status (ie. Competitor, Official, etc.)		

SECTION II		
Date of Accident	Hour	AM/PM
Location of Accident		
Type of Injury		
Accident first notified by	Date	
First Aid provided by		
Nature of Treatment / Medication Given		
Name of Hospital attended		
Location of Hospital		
Date of Admittance	Hour	AM /PM.
Date of Discharge	Attending Physician or Dentist	
Date of First Treatment		



SECTION III Describe fully how the accident occurred (cause)
Weather conditions at the time of accident (if applicable)

SECTION IV (your Sportguard 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/spouse/parent employment?					
Name of Employer			Name of Insurer		
Address of Employer			Address		
City	Prov.	Postal Code	Policy No.	Certificate	Coverage Limits

CERTIFICATE OF ASSOCIATION OR LEAGUE EXECUTIVE Do not complete this section yourself, have your Association or League President, Coach or Manager complete this section.					
Name of Team			League or Association		
Group Policy No.			Type of Sport		
Was the above player a registered member at the time of injury? <input type="checkbox"/> Yes/No <input type="checkbox"/>					
Was the player injured while taking part in an authorized activity? <input type="checkbox"/> Yes/No <input type="checkbox"/>					
Name			Position with Club		
Telephone No.			Signature		

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

Send complete form along with any invoices for expenses you had to pay yourself to: Oceanic Underwriters Ltd., 625 Howe Street, Suite 650, Vancouver, BC, V6C 2T6. Tel: 604-689-1501. Fax: 604-689-5663. Please do not hesitate to call Oceanic Underwriters Ltd. if you have any questions regarding this form. Instructions are on the reverse side. If you do not have costs at this time, please forward the form only and confirm that you intend to make claim.



ATTENDING PHYSICIAN'S STATEMENT

Please complete this form and return it to your patient

Patient's Name: _____ Age: _____

Address: _____

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Date Discharged: _____

If referred to you, give name of referring physician:

Operations (or other procedures performed):

Date: _____

Date: _____

Date: _____

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

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 condition affecting the present condition?

Date: _____ Signature: _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____



PART 2 DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage _____

2. Is further treatment indicated? NO YES If "Yes", please indicate:

Int. Tooth Code	Treatment indicated – use procedure code if possible	Est. Date – Treatment		
		Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame. _____

Date: Day Month Year Dentist's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL