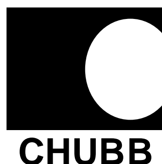


Accidental Medical Expense
Ontario Soccer Association

HOW TO FILE A CLAIM

1. **Complete all items on the attached claim form.**

2. **Attach the following documents:**

   - **Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of service, the type of service rendered, the diagnosis or nature of condition being treated and the provider's name and address.**
   - **Copies of the Explanation of Benefits from your primary insurance carrier**
   - **Attending Physician's Statement**
   - **Club Authorization Statement**

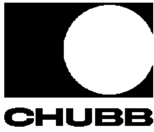
3. **Send the completed and signed claim form and all required documents to:**

CHUBB INSURANCE COMPANY OF CANADA
CLAIMS DEPARTMENT
ONE FINANCIAL PLACE
1 ADELAIDE STREET EAST
TORONTO, ONTARIO M5C 2V9

4. **Retain a copy for your records.**

YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE CALL CHUBB AT 1-800-532-4822



Accidental Medical Expense Claim Form

Insured's Statement

(Please print - Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name ______ **S.I.N.** ______

Insured's Address ______ **Home Phone No.** ______

______ **Work Phone No.** ______

Policy Number (Required) __9906 1905________________

CLAIM INFORMATION

Date of accident (MM/DD/YYYY) ______ **Time and place accident occurred:** ______

Please describe in detail the circumstances of accident (attach separate sheet if needed): ______

Was the accident related to the Insured's occupation? ______ **If so, how?** ______

Please describe the nature of Insured's injuries: ______

Did police or other authorities investigate the accident? (Y/N) ______ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** ______

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name	Street Address	City	Province	Postal Code	Phone

If hospitalized, please provide name and address of hospital(s) where treatment was received:

______

Do you have any other insurance that may provide coverage for this accident or loss? (Y/N) ______ **If yes, please identify name, address, and policy number of all other insurance:** ______

If you do not have any other insurance that would cover this loss please complete the "Certification of No Other Insurance" portion of this form and have it notarized.

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other person who may have knowledge regarding this claim to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signed (Insured or authorized person) ______ **Date** ______ **(MM/DD/YYYY)**

CERTIFICATION OF NO OTHER INSURANCE

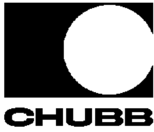
I, ______ **hereby certify that I have no other accident or health insurance or any other insurance covering this loss.**

Signed (Insured or authorized person) ______ **Dated** ______ **(MM/DD/YYYY)**

Sworn and subscribed before me on this ______ **day of** ______, ______.

______

(Notary Public Seal)



Accidental Injury Claim

Attending Physician's Statement

(Please print - Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name ______ **S.I.N.** ______ **Date of Birth** ______ **Marital Status** ______

Insured's Address ______ **Home Phone No.** ______

______ **Work Phone No.** ______

Name and address of employer ______

Policy Number (Required) 9906 1905 **Insured's Occupation** ______

CLAIM INFORMATION

Date of accident: (MM/DD/YYYY) ______ **Date of first treatment: (MM/DD/YYYY)** ______

Please describe in detail the nature of the Insured's injuries, including all applicable ICD-9-CM codes:

Was the accident related to the Insured's occupation? (Y/N) ______ **If so, how?** ______

Was the Insured hospitalized? (Y/N) ______ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? (Y/N) ______

If yes, please describe: ______

Were any surgical procedures performed? (Y/N) ______ **If yes, please list all procedures, including applicable CPT4 codes and dates performed:**

What are the Insured's current subjective symptoms? ______

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? ______

Dates of total disability: (MM/DD/YYYY)

From: ______ **through:** ______

Dates of partial disability: (MM/DD/YYYY)

From: ______ **through:** ______

Date Insured able to return to work: ______

Was the Insured seen by any other physician? (Y/N) ______ **If yes, please list the names and addresses of all other physicians:**

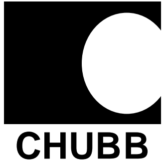
ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: ______ **Phone No.** ______

Address: ______

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) ______ **DATE** ______ **(MM/DD/YYYY)**



Accidental Medical Expense
Club Official Statement

CLUB OFFICIAL AUTHORIZATION

I authorize that the insured named below is/was a member of the Ontario Soccer Association on the date of the reported accident. By signing this form I am verifying that the activity in which the participant participated in was sanctioned by the club and in the case of Exhibition games and tournaments approval was granted by the club's District Association in accordance with the OSA's published rules.

Date of accident: ________ **(MM/DD/YYYY)**

Insured's Name: ________

Name of Club: ________

Club Official (print name): ________

Position of Club Official: ________

I verify that the activity in which the participant participated in was sanctioned by the club and in the case of Exhibition games and tournaments approval was granted by the club's District Association in accordance with the OSA's published rules.

Club Official Signature: ________

Dated: ________ **(MM/DD/YYYY)**