



Accidental Injury The Canadian Ball Hockey Association

HOW TO FILE A CLAIM

1. Complete all items on the attached claim form.
2. Attach the following documents (as applicable):
 - Fully completed Attending Physician Statement (Required for all claims)
 - Copies of Game Sheets, Game Reports, or any Referee Reports
 - Copies of all police reports (if applicable)
 - Copies of any additional documents that support your claim
3. Send the completed and signed claim form and all required documents to:

**CANADIAN BALL HOCKEY ASSOCIATION
56 PENNSYLVANIA AVE., UNIT 5
CONCORD, ONTARIO L4K 3V9**

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 DIANE CLOUTIER AT 1-888-688-9888**



Accidental Injury Claim

The Canadian Ball Hockey Association

Claimant's Statement

Policy # 9906 00 76

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

INSURED INFORMATION

Insured's Name _____ Date of Birth ___/___/___ Marital Status _____

Insured's Address _____ Phone No. (H) _____

_____ Phone No. (W) _____

Insured's Team Name _____ League Name _____

Did the insured have any other insurance, including employee health plans? _____ If yes, please list all companies, type of insurance, policy numbers and insurance amounts: _____

CLAIM INFORMATION

Date of accident ___/___/___ Time and place accident occurred _____

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

Did the accident occur during a game? _____ If so, how? _____

Please describe the nature of Insured's injuries: _____

Please list the names and addresses of all treating physicians and hospitals: _____

Did police or other authorities investigate the accident? _____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

VERIFICATION OF ACCIDENT

Name of Referee verifying accident _____ # _____ Referee's signature _____

Name of League Director verifying accident _____ Director's signature _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured 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 (Claimant or authorized person) _____ DATE ___/___/___

CBHA OFFICE USE ONLY

Date claim received ___/___/___ Date claim processed ___/___/___

Approved by _____ CBHA rep signature _____ Date ___/___/___