



# **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 CHUBB AT 1-800-532-4822**



**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 \_\_\_\_/\_\_\_\_/\_\_\_\_ CBHA Claim# \_\_\_\_\_ Date claim processed \_\_\_\_/\_\_\_\_/\_\_\_\_

Approved by \_\_\_\_\_ CBHA rep signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_