

COMMERCIAL BROKER

Sports-Can
INSURANCE CONSULTANTS LTD.

**BRADLEY'S INSURANCE
(STITTSVILLE) LTD.**

1469 STITTSVILLE MAIN STREET, BOX 1234
STITTSVILLE, ONTARIO K2S 1B3
OFFICE (613) 836-2473 EXT. 202
FAX: (613) 551-1672
DSIM@BRADLEYSINSURANCE.COM
WWW.BRADLEYSINSURANCE.COM

**NOTIFICATION OF CLAIM
ATHLETICS GROUP DEPARTMENT**

Full Name of Insured Person

Male/Female

Date of Birth D/M/Y

If a Minor, give Full Name of Parent or Guardian (Relationship)

Name of Team or League For Which You Were Playing

Sport

Date of Injury

Date First Treated By Dentist (If applicable)

Explain, in Detail, How the Accident Occurred?

Was It During a Practice Period of Playing a League Game?

Where Game or Practice was Taking Place

Nature of Injury

Name of Dentist or Doctor

Address

Apt.

City

Province

Postal Code

What Other Hospital, Medical or Dental Insurance Do You Have?

Signature of Insured or Guardian

Date

Telephone Number

Address

Apt.

City

Province

Postal Code

CERTIFICATE OF TEAM MANAGER OR CLUB EXECUTIVE

Name of Team/League/Association

Policy Number or Certificate Number

National Capital Amateur Football Assoc. (NCAFA)

SC10608

What Sport is Team Engaged In?

Was He/She Injured While Playing in a League Game or in a Practice?

Was the Above Player a Member At The Time of Injury?

On What Date Did He/She Join the Team?

Signed

State Position in Club

Telephone Number

Address

Apt.

City

Province

Postal Code

CLAIM NO. _____

SC10608 – National Capital Amateur Football Assoc. (NCAFA)

LAST NAME: _____

**SPORTSCAN
INSURANCE CONSULTANTS**

OTHER INSURANCE DECLARATION FORM

The Insurance Policy as purchased by your sports organization provides for coverage *in excess* of any private or government medical/dental plan. **If you incur medical or dental expenses as a result of this sports injury, you are required to submit those expenses to your government or private medical/dental plan first.**

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amount of *expenses not covered* to your sports association for processing.

Please clarify your situation by checking one of the following:

_____ Yes I have private coverage but I do not believe that they will provide full reimbursement and would ask that you keep my claim open until we receive clarification of the amount of the expenses not covered by them, at which time I will forward the amount not covered by them to you for your consideration.

_____ No, I do not maintain any medical/dental coverage. The expenses I am submitting are not covered by any other plan.

If you are a minor, then your parents or legal guardian must complete this form on your behalf.

DATE: _____

NAME: _____
(Please Print)

SIGNATURE: _____

PLEASE RETURN AS SOON AS POSSIBLE, ALONG WITH ANY EXPENSES INCURRED TO DATE.