AIG

Member Companies of American International Group, Inc.

American Home Assurance Company
Accident & Health Claims Department
145 Wellington St. West
Toronto, Ontario M5J 1H8
Phone: (416) 596-4005 Fax: (416) 596-4067

**PLEASE PRINT**

**POLICY NO.: SRG**

## CLAIMANT'S STATEMENT- please ensure that original claim documents and invoices are submitted

Surname: Given Name

Address:
(Street & No.)

Apt./Unit No.: Telephone No.: ( )

City/Town Province Postal Code:

Date of
Birth: Height: Weight: Sex: ☐ Male ☐ Female

1. Date of Accident: _____

2. Location of Accident: _____

3. Full details of accident and injury sustained: _____

4. Did the accident occur at a sanctioned event sponsored by the Policyholder? ☐ Yes ☐ No

   Explain: _____

5. Have you had a similar injury previously? Yes_____No_____

   Provide dates and details: _____

6. Name and Address of Physician: _____

7. Where and when did your Physician first attend you? _____

8. Names and Addresses of any other physicians who may have treated you as the result of this accident.

9. What other accident or health insurance do you have?

   Company: _____ Indemnity: _____

**I hereby certify that the above answers are both true and complete:**

Signature of Insured or Insured Person's Parent/Guardian (if under 18): _____ Date: _____

**PERSONAL INFORMATION NOTICE:** I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by American Home Assurance Company, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. **CERTIFICATION:** The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim. **AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with American Home Assurance Company, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be as valid as the original.

Signature of Insured or Insured Person's Parent/Guardian (if under 18): _____ Date: _____

## ATTENDING PHYSICIAN'S STATEMENT- The patient is financially responsible for the completion of the form without any expense to the company

**Physician's Name (Print)**

Name: _____

Street: _____

City: _____

Prov. _____ Postal Code: _____

**Patient's Name (Print)**

Name: _____

Street: _____

City: _____

Prov. _____ Postal Code: _____

**Diagnosis including complications (if fracture, specify bone and type of fracture) and Nature of Injury:**

_____

_____

_____

DATE OF

First Attendance D M Y

Actual Loss

**Is condition due to an accident?** Yes ( ) No ( )

**Please outline the treatment plan recommended and prescribed:** _____

_____

_____

_____

**Date of next scheduled follow up appointment:** _____

**Was claimant hospitalized? ( ) No, and if ( ) Yes - Give hospital name, address and date admitted.**

_____

**Names and addresses of other physicians or surgeons, if any, who attended claimant**

_____

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

DATE: _____ SIGNATURE: _____ M.D.

ADDRESS: _____

## ASSOCIATION'S STATEMENT

**Name of Insured:** _____ **Insured's effective date:** _____

**Insured is (please check the appropriate box):** Member/Athlete ☐ Executive ☐ Manager ☐ Coach ☐ Trainer ☐ Official ☐

**Did the injury occur while claimant was participating in a sanctioned event?** NO ☐ YES ☐ **Please describe:** _____

_____

_____

**Description of Injury:** _____

**Please attach a copy of the completed Incident Report related to this event (if available).**

**Date :** _____ **Signature:** _____

**Telephone No.:** _____ **Title:** _____