CHUBB®

ACCIDENT
MEDICAL CLAIM FORM

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No.: SG10508201		
Name:		
Date of Birth:	**Phone #: ( )**	
Address:		
City:	**Province:**	**Postal Code:**
Have you previously submitted a claim to Chubb: ☐ Yes ☐ No	**Date of Accident:**	
Please describe the accident:		
What injuries resulted from the accident?		
Date physician first consulted:		
Name and Address of Physician:		

The above statements are true and correct to the best of my knowledge and belief. I authorize, for a period of not less than twelve (12) and twenty-four (24) months from the date hereof, any physician, practitioner, healthcare provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, workers compensation board or similar plan or organization, the plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance or Chubb Life Insurance Company of Canada, or its representatives, all medical or benefit payment information or any other information or records in its possession that the Insurer may request while administrating my claim. I agree that a photocopy of this authorization shall be as valid as the original.

Claimant Signature _____ Date _____

Are you covered by another Insurance Company for benefits? (If so, please advise the name of the company and provide your policy and certificate numbers and if applicable the explanation of benefits)

Date Serviced	Nature of Accident	Name of Drugs & RX No	Medical Equipment	Amount Charged	Name of Doctor Prescribing Service

IMPORTANT: ALL BILLS MUST BE ATTACHED TO THIS CLAIM FORM.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance Company of Canada, 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. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

ASSOCIATION'S STATEMENT TO BE COMPLETED BY CLUB/ACADEMY ADMINISTRATOR

Name of Insured:
Policy No: SG10508201
Active Registration Period (eligible from/to):
Ontario Soccer Number:
Name of Soccer Club/Academy:
Date of Injury:
This injury occurred in the following sanctioned activity: Game/Practice/Training Camp/Other (explain):
Name of Club/Academy Administrator:
Date:

Signature of Person Authorized by Policyholder _____ Date _____

INSURED'S STATEMENT

I hereby certify that the above information is true and correct and that all expenses listed were incurred only by the patient indicated. I understand that Chubb Insurance or Chubb Life Insurance Company of Canada may contact my doctor, pharmacist, or any other person and I hereby authorize the release of whatever additional information may be required and that a photocopy of this release shall be deemed as valid as the original.

Insured Signature _____ Date _____

PLEASE ENSURE THAT YOU HAVE ENCLOSED ALL ORIGINAL RECEIPTS.

CHUBB

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY

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PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Patient's Name:	**Age:**

The patient is responsible for the securing of this form and any charge, which may be made for completion.

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

TO PHYSICIANS - PLEASE NOTE As you can appreciate, the information provided by you is the most important in our assessment of impairment. We are asking for your cooperation in providing pertinent information regarding the diagnosis, signs and symptoms, as well as details of your patient's limitations and restrictions.

PLEASE INFORM YOUR PATIENT THAT IF THIS CLAIM IS A RESULT OF DEGENERATIVE DISC DISEASE, OR ALL STRAINS / SPRAINS, BENEFIT PAYMENTS WILL BE LIMITED TO A MAXIMUM OF 15 DAYS PER OCCURRENCE.

HISTORY

a) Is this condition due to ☐ sickness or ☐ accident?			
b) When did symptoms first appear or accident happen?	**Month:**	**Day:**	**Year:**
c) Date total disability commenced?	**Month:**	**Day:**	**Year:**
d) Has patient ever have same or similar condition? ☐ Yes ☐ No ☐ Unknown			

DIAGNOSIS

a) Diagnosis (including any complications):
Secondary (if applicable):
b) Objective findings (including results of current x-rays, E.C.G.'s or any other special tests):

TREATMENT

a) Date of first visit	**Month:**	**Day:**	**Year:**
b) Date of last visit	**Month:**	**Day:**	**Year:**
c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify):			
d) Has there been a treatment program set up? ☐ Yes ☐ No If "Yes", please provide full details.			
e) Has the patient had surgery in relation to this condition? ☐ Yes ☐ No If "Yes", please provide full details.			
Name of Procedure(s)			
Date (s) performed	**Month:**	**Day:**	**Year:**
f) Name of hospital and date of hospitalization:			

PHYSICAL IMPAIRMENT

Is patient ☐ ambulatory ☐ house confined ☐ bed confined ☐ hospital confined
If ambulatory and/or house confined, please complete the section below.
☐ No limitation of functional capacity; capable of strenuous activity
☐ Medium limitation of functional capacity; capable of light activity
☐ Minimal limitation of functional capacity; capable of moderate activity
☐ Severe limitation of functional capacity; Incapable of minimal activity
Remarks:
What are the patient's physical impairments?

PROGNOSIS

a) Does condition prevent patient from performing?	Regular Occupation ☐ Yes ☐ No	Any Other Occupation ☐ Yes ☐ No
b) If "Yes", please indicate when you expect patient will recover sufficiently to perform duties of		
Regular Occupation ☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:		
Any Other Occupation ☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:		
c) If "No", please indicate date patient was able to perform duties of		
Regular Occupation ☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:		
Any Other Occupation ☐ 1-2 Weeks ☐ 3-4 Weeks ☐ Other, Specify:		

REHABILITATION

a) Is patient a suitable candidate for trial employment?	Regular Occupation ☐ Yes ☐ No	Any Other Occupation ☐ Yes ☐ No
b) If "Yes", when could trail employment commence?		
☐ Full Time Month: Day: Year:	☐ Part Time Month: Day: Year:	
If "No", please explain.		

REMARKS

PLEASE PROVIDE COPIES OF ALL DIAGNOSTIC TEST RESULTS AND CONSULTATION REPORTS PERTINENT TOTHE ABOVE NOTED CONDITION.

Physician's Name:		
Degree:	**Phone: ( )**	**Fax: ( )**
Address:		
City:	**Province:**	**Postal Code:**

Signature _____ Date _____