TEAM: ______________________________

NAME OF PLAYER: ______________________________

OTHER INSURANCE DECLARATION FORM

The Accident Policy purchased by your sports association provides medical/dental coverage in excess of any private or government medical/dental plan. **If you incur medical or dental expenses as a result of your sports accident, you are required to submit those expenses to your government or private medical/dental plan first. Only expenses not covered by MSP** *(the provincial medical plan for the province you reside in)* **will be considered. Any primary coverage you have in excess of the provincial plan must also be utilized first.**

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts *not paid* 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 private medical/dental coverage. The expenses I am submitting are not covered by any other primary plan.

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

DATE: ______________________________.

NAME: ______________________________.
(Please Print)

SIGNATURE: ______________________________

THIS FORM IS TO BE SUBMITTED WITH EVERY NIHA ACCIDENT CLAIM FORM, DULY COMPLETED AND SIGNED.

NIHA-CANADA INJURY REPORT

See reverse for mailing address.

Forms must be filled out in full or form will be returned. *This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned inline hockey activity.*

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF INJURY. INJURY DATE: ____/____/____

INJURED PARTICIPANT: ☐ Player ☐ Team Official ☐ Game Official ☐ Spectator

Name: ____________________________ Birthdate: _____/_____/_____ Sex: ☐ M ☐ F

Address: ________________________ City/Town ____________________

Province: ____________ Postal Code: ________ Phone: (_____) ____________

Parent/Guardian: ____________________________________

DIVISION:
☐ Tyke/Atom ☐ Mite ☐ Squirt ☐ Peewee
☐ Bantam ☐ Midget ☐ Junior ☐ Senior

CATEGORY:
☐ House League ☐ Rep/Travel ☐ Regional/Provincial Team
☐ Adult Rec ☐ Other ____________________

BODY PART INJURED: * visit theHockey Canada web-site for an optional questionnaire *

Head: ☐ Eye Area ☐ Face ☐ Throat ☐ Dental ☐ Skull

Back: ☐ Neck ☐ Upper ☐ Lower

Trunk: ☐ Ribs ☐ Chest ☐ Abdomen

Arm ☐ **Left** ☐ **Right**: ☐ Shoulder ☐ Hand/Finger ☐ Upperarm ☐ Forearem/Wrist ☐ Elbow ☐ Collarbone

Pelvis: ☐ Hip ☐ Groin

Leg ☐ **Left** ☐ **Right**: ☐ Thigh ☐ Foot ☐ Knee ☐ Toe ☐ Shin ☐ Other

NATURE OF CONDITION:
☐ Concussion ☐ Laceration ☐ Fracture ☐ Sprain ☐ Strain
☐ Contusion ☐ Dislocation ☐ Separation ☐ Internal Organ Injury

ON-SITE CARE: ☐ On-site Care Only ☐ Refused Care
☐ Sent to Hospital, by: ☐ Ambulance ☐ Car

INJURY CONDITIONS: Name of arena/location: ________________________

☐ **Exhibition/Regular Season** ☐ **Playoffs /Tournament** ☐ **Practice** ☐ **Tryouts** ☐ **Other**

☐ Warm-up ☐ Period #1 ☐ Period #2 ☐ Overtime #______
☐ Dry Land Training ☐ Gradual Onset ☐ Other Sport ☐ Other ________________

Was the injured player in the correct league and level for their age group? ☐ **Yes** ☐ **No**
Was this a sanctioned NIHA-Canada inline hockey activity? ☐ **Yes** ☐ **No**

CAUSE OF INJURY:
☐ Hit by Puck ☐ Collision with Boards ☐ Non-Contact Injury
☐ Hit by Stick ☐ Collision on Open Rink ☐ Collision with Opponent
☐ Fall on rink ☐ Checked from Behind ☐ Collision with Net
☐ Fight ☐ Blindsiding

LOCATION:
☐ Defensive Zone ☐ Offensive Zone ☐ Neutral Zone
☐ Behind the Net ☐ 3 ft. from boards ☐ Spectator Area
☐ Parking Lot ☐ Dressing Room ☐ Bench
☐ Other: ________________

WEARING WHEN INJURED:
☐ Full Face Mask ☐ Intra-Oral Mouth Guard
☐ Half Face Shield/Visor ☐ Throat Protector
☐ Helmet/No Face Shield ☐ No Helmet/No Face Shield
☐ Short Gloves ☐ Long Gloves

ADDITIONAL INFORMATION:
Has the player sustained this injury before? ☐ Yes ☐ No
If "Yes" how long ago ________________
Was a penalty called as a result of the incident? ☐ Yes ☐ No
Estimated absence from Inline Hockey? ☐ 1-week ☐ 1-3 weeks ☐ 3+ weeks

DESCRIBE HOW ACCIDENT HAPPENED:
(Attach page if necessary)

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish NIHA-Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, medical records. A photostatic/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: ____________________________ Date: ______________
(Parent/Guardian if under 18 years of age)

TEAM INFORMATION: (To be completed by a Team Official)

Association: ________________________ Team Name: ________________________

Team Official: (Print): ____________________ Team Official Position: ____________________

Signature: ________________________ Date: ________________________

HEALTH INSURANCE INFORMATION:
THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED

Occupation: ☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed ☐ Full-time Student

Employer (If minor, list parent's employer): ________________________

1. Do you have provincial health coverage? ☐ Yes ☐ No Province: ________________
2. Do you have other insurance? ☐ Yes ☐ No **(IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)**
3. Has a claim been submitted? ☐ Yes ☐ No **(IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATION OF BENEFITS.)**

Make Claim Payable to: ☐ Injured Person ☐ Parent ☐ Team ☐ Other ________________

Branch
APPROVAL

PHYSICIAN'S STATEMENT

Physician: ______________________Address: ______________________ Tel: (____)__________

Name of Hospital/Clinic: ______________________ Address: ______________________

Nature of injury: ______________________ Date of First Attendance: ______/______/______

______________________ Claimant will be totally disabled:

______________________ From: ____________To: ____________

Is the injury permanent and irrecoverable? ☐ No ☐ Yes
Give details of injury (degree): ______________________

____

Prognosis for recovery: ______________________

____

Did any disease or previous injury contribute to the current injury? ☐ No ☐ Yes (describe): ______________________

____

Was claimant hospitalized? ☐ No ☐ 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,
Signed: ______________________ Date: ______________________

DENTIST'S STATEMENT

Limits of coverage: $1,000 per tooth. $2,000 per accident
Treatment must be completed within 52 weeks of accident

PATIENT

____________ ____________
Last Name Given Name

____
ADDRESS APT

____
CITY PROV POSTAL CODE

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

DENTIST

PHONE NO:

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

____
SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF $ _________ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

____
Signature of (Patient/Guardian)

____
OFFICE VERIFICATION

DATE OF SERVICE DAY/MO./YR	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE.

NOTE: All benefits subject to insurer payor status, provisions of the policy, NIHA-Canada sanctioned events.

TOTAL FEE SUBMITTED

Mail completed form to the appropriate Branch office:

BCIHA **6671 Oldfield Road, Saanichton, BC V8M 2A1**	**HOCKEY ALBERTA** 1 – 7875 – 48 Ave., Red Deer, AB T4P 2K1	**MIHA** **206-1555 St James St, Winnipeg, MB R3H 1B5**	**OMRHA** **5065 Benson Drive** Burlington, ON L7L 5N7