SPECIAL RISK
INSURANCE MANAGERS

#103-8411 200th STREET
Langley, BC V2Y 0E7
TEL:: (604)888-0050
Toll free 1 800 993 6388
FAX: (604)888-1008

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) _____ Your Employer or that of Parent or Guardian _____

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 _____

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 _____