HUB International Limited
400-4350 Still Creek Drive
Burnaby, BC V5C 0G5
hubinternational.com
604-269-1000

Accident Claim Form

IMPORTANT: This claim form must be **validated** by your Association (section on reverse). Once the claim form is complete and original itemized invoices attached, mail to HUB International within 30 days following the accident.

Insured's Surname:_____ Insured's Given Name: _____

Address: _____ Telephone No. (daytime):_____
Email:_____

City/Town: _____ Province: _____ Postal Code:_____

Date of Birth (M/D/Y): _____Sex: ☐ Male ☐ Female

1. Date of Accident (M/D/Y): _____ Date of Initial Medical attention (M/D/Y):_____
2. Location and full details of accident and nature of injury sustained: _____

   _____
3. Name of Company who carries your Group Hospital or Medical Insurance:_____

   _____
4. Name and address of Family Physician: _____

   _____
5. Name and contact information of witness to this accident: _____

   _____
6. Name and address of Surgeons or Specialists who provided treatment regarding this accident:

   _____

   _____

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 Various Underwriters as arranged by Special Risk Insurance Managers Ltd., 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 Various Underwriters as arranged by Special Risk Insurance Managers Ltd.
Various Underwriters as arranged by Special Risk Insurance Managers Ltd., or representatives thereof, all personal health information, benefit payment, employment or financial 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.

Name of Insured's Parent/Guardian (if under age 18 - print please): _____

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

Date (M/D/Y): _____

PHYSICIAN'S STATEMENT

Name of Patient: _____

Full description of injury sustained: _____

_____

Date of First Attendance (M/D/Y): _____ Date of Actual Loss (M/D/Y): _____

Is loss permanent and irrecoverable? Give degree of loss: _____

_____

Is condition direct result of an accident? ☐ Yes ☐ No

Did any disease or previous injury contribute to loss? ☐ Yes ☐ No If yes, describe: _____

_____

Was Patient hospitalized? ☐ Yes ☐ No If yes, give Hospital Name and Address: _____

_____

Names and Addresses of other Physicians or Surgeons, if any, who attended Patient:

_____

_____

Are you related to or in a business relationship with this patient? ☐ Yes ☐ No

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (please print) : _____
Address: _____
Signature of Attending Physician: _____ Date (M/D/Y): _____
Phone Number: _____ Fax Number: _____

ASSOCIATION STATEMENT

TO BE COMPLETED BY BCPFA

Name of Player/Volunteer: _____ Name of Club: _____

The Individual is: ☐ Member ☐ Volunteer

Was the individual a member or volunteer on the date of the accident? ☐ Yes ☐ No

Did the injury occur while Insured was participating in an activity recognized by the ☐ Yes ☐ No

Association? Please attach a copy of your incident report related to this event (if available).

Signature: _____ *Date: (M/D/Y):* _____

Keith Ryan

Title: Executive Director Phone Number: Email:executivedirector@bcpfa.com

The furnishing of forms shall not be an admission of liability by the Company.