SPECIAL RISK

#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