

**NOTIFICATION OF CLAIM
 ATHLETICS GROUP DEPARTMENT**

Full name of insured person: _____ Male / Female _____ Date of Birth M/D/YR _____

If a Minor, give full name of Parent or Guardian (Relationship) _____

SPORT - SOFTBALL

Name of team or league for which you were playing _____

Date of Injury _____

Date first treated by dentist (If applicable) _____

Explain, in detail, how the accident occurred _____

Was it during a practice or while playing a league game? _____

Where game / 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

SC10356

What sport Is the team engaged In? _____

Did injury occur while playing in a league game or in a practice? _____

SOFTBALL

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 _____

CLAIM NO.: _____

CLUB: _____

LAST NAME: _____

SPORTSCAN
INSURANCE CONSULTANTS

OTHER INSURANCE DECLARATION FORM

The Insurance Policy as purchased by your sports organization provides for coverage in excess of any private or government medical/dental plan. **If you incur medical or dental expenses as the result of a sports injury, you are required to submit those expenses to your government or private medical/dental plan firstly.**

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts of *expenses not covered* to your sports association for processing.

Please clarify your situation by checking one of the following:

_____ YES, I have private coverage and will be submitting my claim directly to my private insurers.

_____ 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 medical/dental coverage. The expenses I am submitting are not covered by any other plan.

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

DATE: _____

NAME: _____
(Please Print)

SIGNATURE: _____

**PLEASE RETURN AS SOON AS POSSIBLE, TO SOFTBALL ALBERTA
ALONG WITH ANY EXPENSES INCURRED TO DATE**