HOCKEY CANADA INSURANCE PROGRAM

When are you covered?

1. Hockey Canada/Branch sanctioned events (league games, tournaments, practices, training camps, sanctioned fundraisers) when playing member teams only!

2. Transportation directly to and from the arena or venue.

3. Accommodations while billeted or at a hotel during a Hockey Canada/Branch sanctioned hockey activity.

Major Medical / Dental Coverage

Please refer to pages 21-33 of the "Safety for All" handbook for complete details of the Hockey Canada Insurance program including the policy limits.

This insurance augments Provincial, Medical and Hospital plans. It covers players, coaches, referees and other designated volunteers against accidents that occur during participation in a Hockey Canada/Branch sanctioned activity.

This plan is designed to provide coverage for those who might otherwise not be covered by any other group health insurance plan. It can also serve as a supplement to other similar coverage an individual or family may hold, to achieve maximum allowable coverage. It is not applicable as an addition when another plan's coverage meets or exceeds the allowable amount.

How to make a Claim

1. **SECURE** a Hockey Canada Injury Report Form from your team or Minor Hockey Association. In the event that there are none available, contact Hockey Manitoba or download the form at www.hockeymanitoba.mb.ca under the menu option '*Insurance*'.

2. **COMPLETE** the form in its entirety. Have your team official complete the team section and your Doctor/Dentist complete the back of the form.

3. **SUBMIT** the fully completed form to your Branch office (along with any receipts or invoices) ***within 90 days of the date of injury***.

NOTE:

- Only Injury Report Forms received in the Branch office ***within 90 days of the date of injury*** will be accepted.

- Forms must be completed in their entirety or the forms will be returned.

- Only original receipts and/or invoices are acceptable (If originals have been forwarded to a primary insurer, copies are acceptable). **DO NOT FAX IN CLAIMS**

- Hockey Manitoba recommends that members pay ambulance invoices and request personal reimbursement. Hockey Canada will not cover any late charges to these invoices and the reimbursement process can take some time.

- Hockey Canada is **strictly a supplemental insurer**. If you have access to any other insurance, you **MUST** pursue your claim through them first. Hockey Canada shall cover those costs not covered by your primary insurance to our policy limits.

- For **all teams travelling to the USA** for sanctioned tournaments/games: All players **MUST** have some form of primary insurance to be eligible for Hockey Canada's supplemental insurance

- To all teams acquiring players from the USA: all **USA players MUST have primary insurance coverage** to be eligible for Hockey Canada's supplemental insurance.

FOR FURTHER INFORMATION ON COVERAGE, POLICY LIMITS AND ADDITIONAL FEATURES OF THE INSURANCE PROGRAM, PLEASE CONTACT YOUR BRANCH OFFICE.

HOCKEY 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 hockey activity

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE: ___/___/___ Mo. Day Yr.

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

Name: _____ Birthdate: ___/___/___ Sex: (M) (F)
Mo. Day Yr.

Address: _____ City / Town: _____

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

Parent / Guardian:

DIVISION:
☐ Initiation ☐ Novice ☐ Atom ☐ Peewee
☐ Bantam ☐ Midget ☐ Juvenile ☐ Junior

CATEGORY:
☐ AAA ☐ AA ☐ A ☐ B ☐ BB ☐ C ☐ CC
☐ D ☐ DD ☐ E ☐ House ☐ Major Junior ☐ Minor Junior
☐ Senior ☐ Adult Rec. ☐ Other _____

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

Head		Back	Trunk	Arm ☐ Left	☐ Right	Pelvis	Leg ☐ Left	☐ Right
☐ Eye Area	☐ Face	☐ Neck	☐ Ribs	☐ Shoulder	☐ Hand/Finger	☐ Hip	☐ Thigh	☐ Foot
☐ Throat	☐ Dental	☐ Upper	☐ Chest	☐ Upper arm	☐ Forearm/Wrist	☐ Groin	☐ Knee	☐ Toe
☐ Skull		☐ Lower	☐ Abdomen	☐ Elbow	☐ Collarbone		☐ 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** ☐ **Try-outs** ☐ **Other**
☐ Warm-up ☐ Period #1 ☐ Period #2 ☐ Period #3 ☐ 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 Hockey Canada activity? ☐ **Yes** ☐ **No**

CAUSE OF INJURY:
☐ Hit by Puck ☐ Collision with Boards ☐ Non-Contact Injury
☐ Hit by Stick ☐ Collision on Open Ice ☐ Collision with Opponent
☐ Fall on Ice ☐ 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 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 Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photo static/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

Branch APPROVAL

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 EXPLANATIONS OF BENEFITS.)**

Make Claim Payable To: ☐ Injured Person ☐ Parent ☐ Team ☐ Other: _____

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 the details of injury (degree): _____

_____

Prognosis for recovery: _____

_____

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

_____

Was the 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 and the best of my knowledge,

Signed: _____ Date: _____

DENTIST STATEMENT

Limits of coverage: $1,250 per tooth, $2,500 per accident
Treatment must be completed within 52 weeks of accident

	UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER
PATIENT LAST NAME GIVEN NAME _____ ADDRESS APT. _____ CITY PROV. POSTAL CODE	DENTIST PHONE NO.	_____ SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION, DIANOGNIS 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 ACKNOWLEGDE THAT THE TOTAL FEE OF $ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR THE 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 CHARGE	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.

TOTAL FEE SUBMITTED

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

Mail completed form to:
Hockey Manitoba
145 Pacific Ave, Winnipeg, MB R3B 2Z6