

# Proof of Loss – Accidental Medical (Sports Insurance)

**the citadel**

Please answer all questions fully -- it helps us to provide better service.

Instructions: Injured Member complete Insured Statement Section; Team Manager or Administrator complete Club Section at bottom of page 1. Attending Physician complete Physician Statement Section on page 2.

Important: If injury involves teeth, please complete Accidental Dental Claim Form. If the Member is covered under any other Medical Insurance plan, the expenses must be submitted to that plan. If there is any unpaid balance, please attach their Payment Statement. Please retain copies of receipts for your files, as originals will not be returned.

Note: This form can be completed in ink (please print) or on-line, however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned along with ORIGINAL medical receipts to

The Citadel General Assurance Company at any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5

2001 University Street, Suite 1850, Montreal, Quebec H3A 2L8

645 – 7<sup>th</sup> Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

## Insured Statement Section

Policy  
Number: \_\_\_\_\_

1. Insured Member's Full Name \_\_\_\_\_
2. Date of Birth   D     M     Y   3. If a Minor, give Full Name of Parent or Guardian \_\_\_\_\_
4. What is your occupation outside of your sports activities? \_\_\_\_\_
5. Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Street City Province Postal Code
6. Name of Team for which you were playing \_\_\_\_\_ 7. Type of Sport \_\_\_\_\_
8. Date of Accident   D     M     Y   9. Date first treated by doctor   D     M     Y
10. Where did accident occur? \_\_\_\_\_
11. Was it during an approved  practice  game  travelling If travelling, please provide the following:  
Date of departure from prov. of residence   D     M     Y   Date of return to prov. of residence   D     M     Y
12. Describe injury \_\_\_\_\_
13. Describe fully how accident occurred \_\_\_\_\_
14. Full Name of Physician who first treated you \_\_\_\_\_  
Address \_\_\_\_\_  
Street City Province Postal Code
15. Full Name(s) and address(es) of other doctor(s) who treated you \_\_\_\_\_
16. Name of hospital if treated in hospital \_\_\_\_\_
17. Date treated in hospital   D     M     Y
18. Do you have any other Hospital or Medical Insurance?  Yes  No  
Plan Name/Policy Number \_\_\_\_\_

I certify to the best of my knowledge that the statements made above are true, correct and complete.

Injured Member's Signature (or Signature of Parent or Guardian if Injured member is a minor) \_\_\_\_\_ ( ) \_\_\_\_\_   D     M     Y    
Complete Telephone Date  
Address \_\_\_\_\_  
Street City Province Postal Code

Please return completed claim form with the "Consent to collect, use and disclose personal information" form

## Club Section

1. Name of Team \_\_\_\_\_ 2. Policy Number \_\_\_\_\_
3. Name of League or Association \_\_\_\_\_
4. What sport is team engaged in \_\_\_\_\_ 5. On what date did player join the team   D     M     Y
6. Was the above player a regular member at the time of injury  Yes  No
7. Was the player injured during an approved activity?  Yes  No  
If yes, an approved  practice  game  travelling

Authorized Signature

Print Name

Official Position/Title

Complete Address

Street City Province Postal Code

Telephone ( ) Date D M Y

Attending Physician Statement Section

Page 2 Policy Number

1. Patient's Name 2. Patient's Age

3. Diagnosis of present condition

(a) Primary (b) Secondary (if applicable)

4. On what dates did you examine the patient? D M Y D M Y D M Y

5. To the best of my knowledge (a) Symptoms first appeared or accident happened D M Y

(b) Patient has had same or similar condition? Yes No If "Yes", state particulars

6. If attended at hospital, name of hospital

Admitted D M Y Time AM/PM Discharged D M Y Time AM/PM

7. If surgery performed, describe

8. If patient referred to you, give name of referring physician

9. Have you referred the patient to a specialist for additional treatments? Yes No If "Yes", please explain

10. Have you referred the patient for physiotherapy treatments? Yes No If yes, date such referral was made: D M Y

Frequency and duration of physiotherapy treatments?

Physician's Name (Print) Physician's Signature

Address Street City Province Postal Code

Telephone ( ) Date D M Y

The patient is responsible for securing this form and for any charges made for its completion.



# Consent to collect, use and disclose personal information (Accident and Sickness Claims)

I authorize The Citadel General Assurance Company ("The Citadel") and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for The Citadel;

for the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by The Citadel will be entered into a file whose subject is accident and sickness insurance. The file will be kept at The Citadel's offices. Within The Citadel, this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer  
 The Citadel General Assurance Company  
 1075 Bay Street  
 Toronto, Ontario M5S 2W5  
[CIT-Privacy@citadel.ca](mailto:CIT-Privacy@citadel.ca)

This consent shall be valid for the length of time necessary for The Citadel to achieve the purposes listed above. I may withdraw this consent at any time by giving The Citadel written notice of withdrawal. I understand that withdrawal of my consent might result in The Citadel being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

Date of the occurrence   D     M     Y   Cause (accident, illness, etc.): \_\_\_\_\_

Signature of Insured \_\_\_\_\_ Print Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Date   D     M     Y   Telephone (    ) \_\_\_\_\_

Address \_\_\_\_\_  
 Street & Number \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Where the claim is for the Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

Signature of Authorized Representative \_\_\_\_\_ Print Name \_\_\_\_\_ Date   D     M     Y  

Relationship to the Insured: \_\_\_\_\_

The completed authorization can be returned to The Citadel General Assurance Company at any of the following addresses:  
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 2001 University Street, Suite 1850, Montreal, Quebec H3A 2L8  
 645 – 7<sup>th</sup> Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8