SPECIAL RISK
INSURANCE MANAGERS

NOTIFICATION OF CLAIM
ATHLETICS GROUP DEPARTMENT

PLEASE SEND COMPLETED FORM TO:
BC Lacrosse Association
#101 – 7382 Winston Street
Burnaby, BC V5A 2G9
E-Mail: info@bclacrosse.com
Fax: (604) 421-9775

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 _____

#103-8411 200th Street
Langley, BC V2Y 0E7

Tel: (604) 888-0050
Fax: (604) 888-1008

Royal Claims Services Ltd

CLAIM NO: _____

INSURED: _____

NAME: _____

(Above office use only)

OTHER INSURANCE DECLARATION FORM

The Accident Policy as purchased by your sports association provides coverage in excess of any private or government medical/dental plan. **If you incur medical or dental expense as the result of sports injury, you are required to submit those expenses to your government or private medical dental plan. Only expenses not covered by MSP (the provincial plan for province you reside in) will be considered. Any primary coverage you have in excess of the provincial plan must also be utilized first.**

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

Please clarify your situation by checking on of the following:

☐ Yes, I do 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 private medical/dental coverage. The expenses I am submitting are not covered by any other primary plan.

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

DATE: _____

NAME: _____

(Please Print)

SIGNATURE: _____

THIS FORM IS TO BE SUBMITTED WITH EVERY SPORTS ACCIDENT CLAIM FORM, DULY COMPLETED AND SIGNED.

PLEASE SEND ALL FORMS TO:

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#101 - 7382 Winston Street
Burnaby, BC V5A 2G9
FAX: 604-421-9775
E-Mail: dave@bclacrosse.com

Royal Claims Services Ltd

BC Lacrosse Medical Reporting Form

(to be completed by physician and returned to patient)

Name of Patient:		**Name of Physician:**	
Birthdate of Patient		**Name of Medical Facility:**	
Patient Address:		**Address of Physician:**	

Date of Accident :	
Date of Initial Exam:	
Name of Family Doctor:	
Hospitalization required including date admitted?	
Please indicate diagnosis and initial treatment:	
Please state if any further treatment required:	
Has the patient ever had a comparable or same condition?:	
If yes , please indicate when and specify:	
Does the patient have any condition that would influence current infirmity?	

Physicians Signature : _____ **Date:** _____

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Royal Claims Services Ltd

Dental Claims Form

Name of Patient: _____ **Name of Dentist :** _____

Patient Address: _____ **Address of Dentist:** _____

Service date			Procedure Code	Tooth Code	Dentist Fee	Lab Fee	Total Charges
DD	MM	YYYY					

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.

Patients Signature:

This is an accurate statement of services performed and the total fee due and payable E& OE

Office Verification :

Nature of injury, including details : **(Dentist Use only)**

Further Treatement required. **(Pre-determination)**

Procedure codes	Procedure description	Tooth Code	Dentist Fee	Lab Fee	Total Charges	Estimated Timeline		
						DD	MM	YYYY

Additional Treatment Details. **(Dentist Use only)**

*****Please submit all claims to the BC Lacrosse #101-7382 Winston Street Burnaby BC V5A 2G9*****