ACCIDENTAL INJURY
HOW TO FILE A CLAIM

1. The claimant shall complete, sign and date ‘Claimant Section’.
2. Your league President shall verify the accident and ensure the ‘Claimant Section’ and ‘Physician/Dentist Section’ is completed. Your league President shall also complete the ‘Member League Approval’ section.
3. The claimant shall have the attending physician or dentist complete the ‘Physician or Dentist Section’. Attach the following documents (as applicable):
    - copy of game report;
    - copy of police report; and/or
    - copy of any additional documents that support your claim.
4. Email a copy of the completed ‘Accidental Injury Claim Form’ and all required documents to **info@cornholecanada.ca** within 30 days of the injury.
5. Retain a copy for your records.

YOU WILL BE CONTACTED BY A CLAIMS ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED AND TO PROVIDE INFORMATION WHERE TO SUBMIT RECEIPTS FOR THE CLAIM.

ACCIDENTAL INJURY CLAIM FORM – Policy Number: SPO11363

IMPORTANT:

This form must be emailed within thirty (30) days of the accident. Once the claimant has completed the 'Claimant Section' and had the 'Physician or Dentist Section' completed by the attending Doctor/Dentist the 'Accidental Injury Claim Form' must be **signed and approved** by your League President.

****The furnishing of forms shall not be an admission of liability by the Company****

CLAIMANT SECTION

Claimant Name:	Gender:
Address:	City/Town:
Province	Postal Code:
Date of Birth:	Phone Number:
Email:	

BODY PART INJURED

Arm	Left	Right	Leg	Left	Right	Head	Trunk	Back
Shoulder	☐	☐	Shin	☐	☐	☐ Eye	☐ Abdomen	☐ Lower
Upper Arm	☐	☐	Knee	☐	☐	☐ Face	☐ Chest	☐ Upper
Collarbone	☐	☐	Toe	☐	☐	☐ Throat	☐ Ribs	☐ Neck
Elbow	☐	☐	Thigh	☐	☐	☐ Skull	**Pelvis**	**Other:**
Hand/Finger	☐	☐	Foot	☐	☐	☐ Teeth	☐ Hip	
Forearm/Wrist	☐	☐					☐ Groin	

NATURE OF CONDITION

☐ Concussion ☐ Contusion ☐ Dislocation ☐ Fracture ☐ Intern Organ
☐ Laceration ☐ Separation ☐ Sprain ☐ Strain

DETAILS OF ACCIDENT

Date of Accident:	Approx. time of accident:
Date of initial medical attention:	Address of accident:
Area of facility that injury occurred:	Was this a sanctioned Cornhole Canada activity?
Details of accident:	

HEALTH INSURANCE INFORMATION

Do you have Province health coverage?	☐ Yes ☐ No	If, YES, Which Province:
Do you have other insurance?	☐ Yes ☐ No	*If 'YES', please submit the claim to your primary health insurer.
Has a claim been submitted?	☐ Yes ☐ No	*If 'YES', please forward the primary health insurer explanation of benefits.

I hereby authorize any health care facility, physician, dentist or other person who has attended or examined me/my child, to furnish BFL Canada and Cornhole 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. The statements I provide in completing this form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief.

Date:_____

Name:_____

Signature:_____

Parent/Guardian please sign if claimant is under 18 years of age

MEMBER LEAGUE APPROVAL

President's Name:_____

League Name:_____

Is the claimant a member of the league?_____

Is the claimant a member of Cornhole Canada?____

Did the injury occur during a league activity?_____

Date:_____

Name:_____

Signature:_____

PHYSICIAN SECTION

Name of Patient:	Nature of Injury:
Give details of injury:	
Date of First Attendance:	Claimant will be disabled: FROM TO
Is the injury permanent and irrecoverable? ☐ Yes ☐ No If yes, progress for recovery:	
Did any disease or previous injury contribute to current injury? ☐ Yes ☐ No If yes, please describe:	
Was the patient hospitalized? ☐ Yes ☐ No If yes, please give hospital name, address and date:	
If any, names and addresses of other physicians or surgeons who attended the patient:	

Physician Name:	Name of Hospital/Clinic:
Address:	City/Town:
Province:	Postal Code:
Phone Number:	
I certify that the above information is correct and to the best of my knowledge. Date:	Signature:

DENTIST SECTION

Name of Patient:		Date of First Attendance:		
Give details of injury:				
Date of Service	Procedure	Dentist Fee	Lab Fee	Total Charge

Dentist Name:	Name of Clinic:
Address:	City/Town:
Province:	Postal Code:
Phone Number:	
I certify that the above information is correct and to the best of my knowledge. Date:	Signature: