



**AIG Insurance Company Of Canada**  
 145 Wellington Street West  
 Toronto, ON M5J 1H8  
 ahclaimscan@aig.com

**Return to:**

**Ringette Québec (Stade Olympique)**  
 4545, Pierre-De-Coubertin  
 Montreal, QC, H1V 0B2

**Accident Claim Form**

**IMPORTANT:** This claim form must be **validated** by your Association (section on reverse). Once the claim form is complete and original itemized invoices attached, mail to **Ringette Québec** within 30 days following the accident.

**Name of Policyholder: Ringette Québec**  
**Policy No.: SRG 9027681**

Insured's Surname: \_\_\_\_\_ Insured's Given Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone No. (daytime): \_\_\_\_\_  
 Email: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Sex:  Male  Female

1. Date of Accident (M/D/Y): \_\_\_\_\_ Date of Initial Medical attention (M/D/Y): \_\_\_\_\_

2. Location and full details of accident and nature of injury sustained: \_\_\_\_\_  
 \_\_\_\_\_

3. Name of Company who carries your Group Hospital or Medical Insurance: \_\_\_\_\_  
 \_\_\_\_\_

4. Name and address of Family Physician: \_\_\_\_\_  
 \_\_\_\_\_

5. Name and contact information of witness to this accident: \_\_\_\_\_  
 \_\_\_\_\_

6. Name and address of Surgeons or Specialists who provided treatment regarding this accident:  
 \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL INFORMATION NOTICE:** I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

**CERTIFICATION:** The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

**AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada.

AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Name of Insured's Parent/Guardian (if under age 18 - print please): \_\_\_\_\_

Signature of Insured or Insured's Parent/Guardian (if under age 18): \_\_\_\_\_

Date (M/D/Y): \_\_\_\_\_

**PHYSICIAN'S STATEMENT**

Name of Patient: \_\_\_\_\_

Full description of injury sustained: \_\_\_\_\_  
\_\_\_\_\_

Date of First Attendance (M/D/Y): \_\_\_\_\_ Date of Actual Loss (M/D/Y): \_\_\_\_\_

Is loss permanent and irrecoverable? Give degree of loss: \_\_\_\_\_  
\_\_\_\_\_

Is condition direct result of an accident?  Yes  No

Did any disease or previous injury contribute to loss?  Yes  No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Was Patient hospitalized?  Yes  No If yes, give Hospital Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Names and Addresses of other Physicians or Surgeons, if any, who attended Patient:  
\_\_\_\_\_  
\_\_\_\_\_

Are you related to or in a business relationship with this patient?  Yes  No

**These statements are true and complete to the best of my knowledge and belief.**

Name of Attending Physician (please print) : \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Attending Physician: \_\_\_\_\_ Date (M/D/Y): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**ASSOCIATION STATEMENT**

Name of Member: \_\_\_\_\_ Effective date of insurance: \_\_\_\_\_

Was the individual a member on the date of the accident?  Yes  No

Did the injury occur while Insured was participating in an activity recognized by the Association?  Yes  No

Please attach a copy of your incident report related to this event (if available).

Signature: \_\_\_\_\_ Date (M/D/Y): \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

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