C/O:
SBC Insurance Agencies Ltd.
https://sbcinsurance.com/
claims@sbcinsurance.com

MARKEL PLAY ATHLETIC ACCIDENT CLAIM FORM

SECTION I (please print)

Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone ( )	Business Phone ( )	

SECTION II

Date of Accident	Hour a.m. / p.m. (circle one)
Location of Accident	
What is the injury?	
Date of First Treatment	
Name of Hospital taken to	
Date of Admittance	Hour a.m. / p.m. (circle one)
Date of Discharge	Name of Attending Physician or Dentist

SECTION III Describe fully how the accident happened.

SECTION IV (your sport accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses)
What medical coverage do you have through your/spouse/parent employment?

Name of Employer			Name of Insurer	
Address of Employer			Address of Insurer	
City	Prov.	Postal Code	Policy No.	Certificate Number

SECTION V

I hereby certify that all the information provided above is correct.

Claimant's / Guardian's Signature	Date

Send completed form along with any invoices for expenses you incurred to –

By email:
SBC Insurance Agencies Ltd.
https://sbcinsurance.com/
claims@sbcinsurance.com

Please call your insurance broker if you have any questions regarding this form. Instructions are on the reverse side. If you do not have invoices at this time, please forward the form only to confirm that you intend to make a claim.

CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE

Do not complete this section yourself; have your Club or League President, Coach or Manager complete this section.

Name of Team	League or Association
Accident Policy No.	Type of Sport
Was the above player registered at the time of the injury? Yes/No (circle one)	
Was the player injured while taking part in an authorized activity? Yes/No (circle one)	
Name	Position with Club
Telephone No.	Signature

INSTRUCTIONS

Mci 'a i gh dfcj]XY U``]bZcfa Uh]cb fYei YghYX/]bWta d`YhY Zcfa g VUbbch VY dfcWggYX"

=A DCFH5BH DC=BHG HC F9A 9A 69F K <9B 7CA D@9H=B; MCI F 7@5=A .

%" Mci f]bgi fYf a i gh fYWY]j Y bch]W cZ mci f UWV]XYbh k]h\]b "$ XUmg cZ h\Y UWV]XYbh XUhY UbX fYWY]j Y VU]a XcWi a YbhUh]cb k]h\]b -$ XUmg"

&" 5@@ VU]a g a i gh VY gi Va]hhYX k]h\ ]hYa]nYX gHUhYa Ybhg UbX dU]X fYWY]dhg fcf][]bU g UfY fYei]fYX]Z h\YfY]g bc ch\Yf Wj YfU[Y Uj U]UV`Yž k \]W]bX]WUhY
- DUh]YbhEg bUa Y
- HmdY cZ difWUgY cf gYfj]WY
- 8UhY cZ YUW difWUgY cf gYfj]WY
- 5a ci bh WU Uf[YX Zcf YUW difWUgY cf gYfj]WY

' " 5 d\mg]W]Ub gHUhYa Ybh Wtb Z]fa]b[X]U[bcg]g UbX fYWta a YbXYX hfYUha Ybh]g fYei]fYX]Z mci UfY VU]a]b[ch\Yf h\Ub XYbhU cf Ua Vi `UbW YI dYbgY"

(" Cb`m VU]a g ]b YI WYgg cZ h\Y XYXi Wh]V`Y gdYW]Z]YX]b mci f d`Ub k]`` VY Wtb g]XYfYX Zcf dUma Ybh i d hc mci f a UI]a i a VYbYZ]hg"

)" 9I dYbgYg Y`][]V`Y i bXYf Ubm ch\Yf \YU`h\ WUfY d`Ub fgL a i gh VY gi Va]hhYX hc h\Uh d`Ub fgL" Mci f gdcfh UWV]XYbh dc`]Wmk]`` dUm cb`m h\Y Ua ci bh cZ YI dYbgYg h\Uh UfY bch Y`][]V`Y k]h\ Ubm ch\Yf]bgi fYf"

- = MCI 5F9 7@5=A =B; 5BMC: H<9 69B9: =HG @=GH98 69@CK ž MCI A I GH =B7@I 89 H<9 : C@@CK =B; =B: CFA 5H=CB K =H< MCI F 7@5=A . fD`YUgY WYW_ mci f d`Ub XYHU]g Zcf h\Y Wtb X]h]cbg i bXYf k \]W h\YgY VYbYZ]hg UfY Y`][]V`Y" Mci a i gh \Uj Y fYei]fYX UbX fYWY]j YX a YX]WU #XYbhU hfYUha Ybh Wta a YbW]b[k]h\]b " $ XUmg cZ h\Y UWV]XYbh XUhY"L

- : CF 69B9: =HG BCH @=GH98 69@CK ž D@95G9 7CBH57H H<9 =BGI F9F : CF 7@5=A G DFC798I F9

5" DF9G7F=698 8FI ; G
   - BUa Y cZ a YX]WUh]cb cf Xfi [
   - 8UhY cZ difWUgY
   - 5a ci bh WU Uf[YX

6" G9FJ=79G C: D<MG=7=5BG ž 7<=FCDF57HCF ž CGH9CD5H<
   - D\mg]W]Ub fYZYffU
   - HmdY cZ gYfj]WY
   - 8UhY cZ YUW hfYUha Ybh
   - 5a ci bh WU Uf[YX Zcf YUW hfYUha Ybh
   - 8UhY cZ hfYUha Ybh dU]X Vm Dfcj]bW]U A YX]WU D`Ub/ ]Z df]j UhY ZYYg Udd`mž Wtb Z]fa]b[Wtj YfU[Y \Ug VYYb YI \Ui ghYX

7" <CGD=H5@ FCCA 577CA AC85H=CB
   - Bch Ub Y`][]V`Y YI dYbgY

8" 5A 6I @5B79 fPa Yf[YbWm hc <cgd]hU cb`mL
   - 8UhY cZ gYfj]WY
   - D`UWY g Ua Vi `UbW hU_Yb Zfca UbX hc
   - 5a ci bh WU Uf[YX

9" J =G=CB 75F9
   - =Z mci f]b^i fm fYWY]j YX a YX]WU hfYUha Ybh UbX fYgi `hYX ]b h\Y `cgg cf XUa U[Y cZ YmYk YUf ž cf h\Y fYei]fYa Ybh cZ YmYk YUf Xi Y hc UWV]XYbh
   - 5b YI d`UbUh]cb a i gh VY gi Va ]hhYX k ]h\ mci f fYWY]dh hc WU]a h\Y `a]hYX VYbYZ]h

: " G7<98I @98 : F 57HI F9 =B89A B=HM
   - =Z mci f]b^i fm fYgi `hg ]b Ubm cZ h\Y ZfUWhi fYg cf X]g`cWUh]cbg `]ghYX cb h\Y dc`]Wm gW YXi `Yž h\YfY a Um VY Ub Ua ci bh dUmUV`Y hc mci / bch a cfY h\Ub cbY Ua ci bh fh\Y `Uf[ YghL ]g dUmUV`Y
   - 5 gHUhYa Ybh Wta d`YhYX Vm h\Y `]WYbgYX d\mg]W]Ub cf gi f[Ycb Wtb Z]fa]b[h\Y ZfUWhi fY#X]g`cWUh]cb

; " A 98=75@6F 579G
   - 5 `YhhYf Zfca h\Y `]WYbgYX d\mg]W]Ub cf gi f[Ycb]bX]WUh]b[h\Y X]U[bcg]gž h\Y gdYW]Z]W a YX]WU bYWYgg]hm Zcf dfYgW]V]b[h\Y VfUWY UbX h\Y hmdY cZ VfUWY dfYgW]VYX a i gh VY gi Va]hhYX k]h\ mci f fYWY]dh
   - A YX]WU VfUWYg fYei]fYX df]a Uf]`m Zcf gdcfh]b[hmdY UWh]j]h]Yg UfY bch Wtj YfYX

<" 89BH5@ 577=89BHG
   - 9I UWh XUhY cZ UWV]XYbh
   - 6fYU_Xck b cZ gYfj]WYg dYfZcfa YX
   - 7]fWi a ghUbWYg gi ffci bX]b[h\Y UWV]XYbh
   - =g h\YfY ch\Yf XYbhU Wtj YfU[Y3 9bWcgY XYHU]g"
   - 7cbZ]fa Uh]cb h\Uh hfYUha Ybhg cb`m fYgi `hYX hc h\Y UWV]XYbh
   - Dfcj]XY ch\Yf]bgi fYfEg YI d`UbUh]cb
   - 5fY Zi fh\Yf hfYUha Ybhg Ygh]a UhYX3

=" G9FJ=79G 5J 5=@56@9 K =H< =B H<9 DFCJ =B79 5@ D@5B
   - Mci f Gdcfh 5WV]XYbh Dc`]Wm XcYg bch a U_Y dUma Ybh Zcf Ubm gYfj ]WYg cf hfYUha Ybh h\Uh ]g Uj U]UV`Y k]h\]b h\Y dfcj]bW]U d`Ubž k \Yh\Yf h\YfY ]g Ybfc`a Ybh]b h\Y dfcj]bW]U d`Ub cf bch

MCI F GDCFH 577=89BH DC@=7M A 5M =B7@I 89 5 898I 7H=6@9 5B8#CF D9F 79BH5; 9 C: F9=A 6I FG9A 9BH"

fP9I Ua d`Y. ` % $$ XYXi Wh]V`Y cf ` ' $ dYf hfYUha Ybh i d hc ` ' $$ dYf UWV]XYbh"L = =B 8CI 6Hž 7<97? MCI F D@5B 89H5=@G"

MARKEL

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PART 1 DENTIST

Dentist's Name ______________________
Address ______________________
City, Province ______________________
Postal Code ______________________
Telephone ______________________

Patient's Last Name ______________ Given Names ______________
Address ______________ Apt. ______________
City, Province ______________________
Postal Code ______________________

Date of Service (D / M / Y)	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charges. E. & OE.

Total Submitted Fee

Dentist's Signature

Date: Day Month Year

FOR PLAN ADMINSTRATOR USE ONLY:
NOTICE TO DENTIST:

Please Note – Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your co-operation will be appreciated.

FOR DENTIST'S USE ONLY.
For additional information Re: diagnosis, procedures or complications and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

Signature of Patient (or Parent/Guardian)

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Signature of Subscriber

CLAIM APPROVED:

Day Month Year
Assessor

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage ______________________

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated – use procedure code if possible	Est. Date – Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame. ______________________

Date: Day Month Year

Dentist's Signature ______________________

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: ______________________ Age: __________

Address: ______________________

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

____

If Hospitalized, give name of hospital: ______________________

Date Admitted: ______________ Discharged: ______________

If referred to you, give name of referring physician:

Operations (or other procedures performed):

______________________ Date: __________

______________________ Date: __________

______________________ Date: __________

Date of first consultation for above: ______________________

Date of first symptoms: ______________ Date of Accident: ______________

Has the patient ever had same or similar condition? ______________________

If yes, please state when and describe: ______________________

Is there any other disease or infirmity affecting the present condition?

Date: ______________ Signature ______________ (M.D.)

Address: ______________________

Certified Specialist ______________________

Phone: ______________________