By Furnishing This Blank the Company Makes No Admission of Liability or Waiver of Its Rights. To Be Completed and Returned Within Fifteen Days.

B.F. LORENZETTI & ASSOC. INC.
Courtiers d'assurances internationaux / International Insurance Brokers

THIS DOCUMENT MUST BE SENT TO :
Ontario Ringette Association
#705 – 1185 Eglinton Ave East,
North York, ON M3C 3C6

Tél: (416) 426-7204
Fax: (416) 426-7359

ACCIDENT CLAIM REPORT

GROUP POLICY HOLDER	POLICY NUMBER	CERTIFICATE NO.
Ringette Canada	SRG 9027681	

INSURED'S FULL NAME	STREET ADDRESS	CITY	PROVINCE

DATE OF BIRTH	HEIGHT AND WEIGHT	MARITAL STATUS	TELEPHONE

OCCUPATION PRIOR TO DISABLEMENT	DUTIES	MONTHLY EARNINGS	WEEKLY EARNINGS

1	Give Full description of injury or disease from which you are now suffering. If an injury, tell when, where and how it happened.	SICKNESS ☐ INJURY ☐
2 A	Have you ever had this, or a similar condition, in the past?	YES ☐ Condition(s): _____
B	If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics	NO ☐ Dates: _____

3 A	Give exact date when illness began, or injury occurred.	**A**	Date: _____
B	When did you first consult a physician for this condition?	**B**	Date: _____
C	When did you become totally disabled (unable to work)?	**C**	Date: _____
D	When were you able to again perform part of your occupational duties?	**D**	Date: _____
E	When were you able to again perform all your occupational duties?	**E**	Date: _____
F	If still totally disabled, when do you expect your disability to terminate?	**F**	Date: _____

4	Hospitals (Give complete names, addresses and dates of confinement.)	NAMES	ADDRESSES	FROM TO
5 A	Give names, addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE
B	Give name, addresses and telephone numbers of usual family physician.			
6	What other accident, sickness or disability insurance do you carry and what organizations or companies have paid you indemnity for sickness or injury?	NAMES	ADDRESSES	BENEFITS
7	What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics).			
8	Names and addresses of Employers and length of employment with each?	NAMES	ADDRESSES	FROM TO

I hereby authorize any hospital, physician or other person who has attended me, or any employer, to furnish American Home Assurance Company or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Approved by: Dated _____

_____ M.D. SIGN YOUR FULL NAME _____

ATTENDING PHYSICIAN

PHYSICIAN'S STATEMENT ON OTHER SIDE

B.F. LORENZETTI & ASSOC. INC.

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ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

ACCIDENT

PATIENT'S NAME AND ADDRESS	AGE

1 A	Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location)	
B	Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain	Yes ☐ No ☐
2 A	When did symptoms first appear or accident happen?	Date _____ Year: _____
B	When did patient first consult you for this condition?	Date _____ Year: _____
C	Has patient ever had same Or similar condition? If "Yes" state when and describe	Yes ☐ No ☐
3 A	Nature of surgical or obstetrical procedure, If any (describe fully)	Date performed _____ Year: _____
B	Charge to patient for this procedure including post-operative care	$ _____
C	If performed in hospital, give name of hospital	_____ Inpatient ☐ Outpatient ☐
4	Give dates of other medical (non-surgical) treatment, if any	Office _____ Home _____ Hospital _____ Nursing Home _____
5	What other services, if any, did you provide patient? (Itemize, giving dates and fees)	
6	Where registered private duty nurse (R.N.) Services necessary?	
7	Is patient still under your care for this condition? If "No" give date your services terminated	Yes ☐ No ☐ Date _____ Year: _____
8 A	How long was or will patient be continuously totally disabled? (Unable to work?)	From _____ Year:____ Thru _____ Year:____
B	How long was or will patient be partially disabled?	From _____ Year:____ Thru _____ Year:____
C	Was house confinement necessary? If "Yes" give dates	Yes ☐ No ☐ From _____ Year:____ Thru _____ Year:____
9	To your knowledge, does patient have other health insurance or Health plan coverages? If "Yes" identify	Yes ☐ No ☐

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	**CITY OR TOWN**	**PROVINCE**	**POSTAL CODE**