

Date: _

HOCKEY CANADA INJURY REPORT



CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. See reverse for mailing address. **INJURED PARTICIPANT:** Player Team Official Game Official Spectator Forms must be filled out in full or form will be Birthdate: ___/__/__ Mo. Day Yr. Name: _ Gender: M returned. This form must be completed for each case where an injury is Address: sustained by a player. ______ Province: ______ Postal Code: ______ Phone: (____) _____ spectator or any other City / Town: person at a sanctioned _____ Email Address: ____ hockey activity. Parent / Guardian: **AGE DIVISION CATEGORY** Under-7 Under-9 Under-13 Adult Rec BB Under-11 AAA Α CC DD House Minor Junior Under-15 Under-18 Under-21 Junior Senior В AA **Major Junior** Other **BODY PART INJURED** NATURE OF CONDITION Head: Arm: Leg: Trunk: Back: Concussion Laceration Fracture Right Left Eve Area Abdomen Neck Sprain Strain Contusion Left Right Face Chest Dislocation Internal Organ Injury Shoulder Shoulder Shin Shin Lower Separation Throat Ribs Upper Upper arm Upper arm Knee Knee Skull Pelvis: Collarbone Collarbone Toe Toe ON-SITE CARE Groin Dental Elbow Elbow Thigh Thigh Hip On-Site Care Only Refused Care Hand/Finger Hand/Finger Foot Foot Other: Forearm/Wrist Forearm/Wrist Sent to Hospital by: **Ambulance** Car Was the injured player in the Was this a sanctioned **INJURY CONDITIONS CAUSE OF INJURY** correct league and level for Hockey Canada activity? Hit by Puck Name of arena/location: their age group? ☐ Yes ☐ No Collision with Boards ☐ Yes ☐ No Non-Contact Injury ☐ Exhibition/Regular Season ☐ Period #2 Hit by Stick ☐ Playoffs/Tournament ☐ Period #3 Collision on Open Ice Collision with Opponent ☐ Practice ☐ Overtime: LOCATION Fall on Ice ☐ Try-outs ☐ Dry Land Training ☐ Defensive Zone ☐ Offensive Zone ☐ Neutral Zone Checked from Behind ☐ Other ☐ Gradual Onset ☐ Behind the Net ☐ 3 ft. from Boards ☐ Spectator Area Collision with Net ☐ Other Sport ☐ Warm-up ☐ Dressing Room ☐ Bench ☐ Parking Lot Fight ☐ Period #1 ☐ Other: _ ☐ Other: ___ Blindsiding I hereby authorize any Health Care Facility, WEARING ADDITIONAL DESCRIBE HOW Physician, Dentist or other person who has WHEN INJURED INFORMATION INCIDENT HAPPENED attended or examined me/my child, to furnish (Attached additional page if necessary) Has the player sustained this injury Hockey Canada any and all information with ☐ Full Face Mask respect to any illness or injury, medical history, before? ☐ Yes ☐ No ☐ Helmet/No Face Shield consultation, prescriptions or treatment and copies ☐ No Helmet/No Face Shield If "Yes" how long ago? of all dental, hospital, and medical records. A photo ☐ Intra-Oral Mouth Guard Was a penalty called as a result of the static/electronic copy of this authorization shall be ☐ Half Face Shield/Visor considered as effective and valid as the original. incident? ☐ Yes ☐ No ☐ Throat Protector Estimated absence from hockey? ☐ Short Gloves (Parent/Guardian if under 18 years of age) \square 1 week \square 1-3 weeks \square 3+ weeks ☐ Long Gloves **MEMBER TEAM INFORMATION HEALTH INSURANCE INFORMATION APPROVAL** THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED (To be completed by a Team Official) ☐ Employed Full-time ☐ Employed Part-time Occupation: ☐ Unemployed ☐ Full-Time Student Association: Employer (If minor, list parent's employer): _ Team Name:__ 1. Do you have provincial health coverage? ☐ Yes ☐ No Province: Team Official (Print): 2. Do you have other insurance? ☐ Yes ☐ No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.) Team Official Position: 3. Has a claim been submitted? ☐ Yes ☐ No Signature: _____ (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To: Injured Person Parent Team Other:



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Participant's name:

Name of Hospital / Clinic: Address:	PHYSICIAN'S STATE	EMENT					
Nature of Injury: Calimant will be totally disabled: From: To:	Physician:			ddress:		Tel: (()
Claimant will be totally disabled: From: To: To: To: It is the injury permanent and irrecoverable? No Yes Prognosis for recovery.	Name of Hospital / Clinic:			Address:			
Did any disease or previous injury contribute to the current injury? No Yes (describe): Vas the claimant hospitalized? No Yes (give hospital name, address and date admitted):	Nature of Injury:		Claimant will be totally disabled: From: To:				
Did any disease or previous injury contribute to the current injury? No Yes (describe): Was the claimant hospitalized? No Yes (give hospital name, address and date admitted): Names and addresses of other physicians or surgeons, if any, who attended claimant: I certify that the above information is correct and to the best of my knowledge, Signed:							d irrecoverable? ☐ No ☐ Yes
Names and addresses of other physicians or surgeons, if any, who attended claimant: Certify that the above information is correct and to the best of my knowledge, Signed:	Give the details of injury (degre			Prognosis fo	or recovery:		
Certify that the above information is correct and to the best of my knowledge, Signed:							
DENTIST STATEMENT Units of coverage: \$1,250 per tooth, \$3,000 per accident. Treatment must be completed within 52 weeks of accident. (Effective September 1st, 2018) Patient Last name Given name Address City / Town Province Postal Code For dentist use only – for additional information, diagnosis, procedures or special consideration. 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. I acknowledge that the total fee of \$ is accurate and has been charged to me for the services rendered. I authorize release of the information contained in this claim form to my insuring company/ plan administrator. DATE OF SERVICE MO. / DAY / YR. PROCEDURE INITIAL TOOTH CODE TOTAL CHARGE Total CHARGE TOTAL CHARGE Total CHARGE TOTAL CHARGE Total CHARGE TOTAL FEE SUBMITTED	Names and addresses of other	r physicians or surge	ons, if any, who a	ttended claimant:			
DENTIST STATEMENT Limits of coverage: \$1,250 per tooth, \$3,000 per accident. Treatment must be completed within 52 weeks of accident. (Effective September 1st, 2018) Patient Last name Given name Address City / Town Province Postal Code For dentist use only – for additional information, diagnosis, procedures or special consideration. 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. I acknowledge that the total fee of \$ is accurate and has been charged to me for the services rendered. Lathorize release of the information contained in this claim form to my insuring company/ plan administrator. DATE OF SERVICE MO. / DAY / VR. PROCEDURE INITIAL TOOTH CODE This is an accurate statement of services performed and the total fee due and payable & oe. TOTAL FEE SUBMITTED				-			
Dentist Dent	Signed:)ate:			
Last name Given name Address Phone No Province Postal Code Phone No SIGNATURE OF SUBSCRIBER	Limits of coverage: \$1,250 per tooth		UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.				
Address City / Town Province Postal Code Phone No 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. I acknowledge that the total fee of \$ is accurate and has been charged to me for the services rendered. I authorize release of the information contained in this claim form to my insuring company/ plan administrator. DATE OF SERVICE MO. / DAY / YR. PROCEDURE INITIAL TOOTH CODE TOOTH SURFACE DENTIST'S FEE LAB CHARGE TOTAL CHARGE Total CHARGE Total FEE SUBMITTED	Patient			Dentist			payable from this claim directly to
Total Code Phone No Province Postal Code Phone No SIGNATURE OF SUBSCRIBER	Last name Given name						
For dentist use only – for additional information, diagnosis, procedures or special consideration. 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. I acknowledge that the total fee of \$ is accurate and has been charged to me for the services rendered. I authorize release of the information contained in this claim form to my insuring company/plan administrator. DATE OF SERVICE MO. / DAY / YR. PROCEDURE INITIAL TOOTH CODE TOOTH SURFACE DENTIST'S FEE LAB CHARGE TOTAL CHARGE	Address						
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DATE OF SERVICE MO. / DAY / YR. PROCEDURE INITIAL TOOTH CODE TOTAL CHARGE	DUPLICATE FORM □	OLOMATURE OF (PAT	ENT (OHADDIAN)	OFFICE VEDI	CIOATION		
MO. / DAY / YR. PROCEDURE CODE TOUTH SURFACE DENTISTS FEE LAB CHARGE TOTAL CHARGE This is an accurate statement of services performed and the total fee due and payable & oe. TOTAL FEE SUBMITTED		Signature of (Patient/Guardian) Office verification					
,		PROCEDURE		TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE
,							
,							
,							
\mathbf{I}						TOTAL FEE SUBM	IITTED

Mail completed form to:

HOCKEY QUEBEC 7665 Boul. Lacordaire, 4e étage MONTRÉAL, QC, H1S 2A7 TEL: 514-252-3079 FAX: 514-252-3158 HOCKEY.QC.CA ASSURANCES@HOCKEY.QC.CA