

## PROOF OF LOSS ACCIDENTAL DENTAL (SPORTS INSURANCE)

Please answer all questions fully - it helps us to provide better service

**Instructions -** Insured member - complete Claimant's Statement; Team Manager or Administrator -complete Club Section at bottom of page 1. Attending Dentist - complete Dental Section on page 2.

Important - If the member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to the Dental plan. If there is any unpaid balance, please attach their payment statement(s).

Claimant's	s Statement			Policy Number	1B7	30		
1. Insured Me	ember's Full Name			2. Date of Birth	D	М	Υ	
3. If a minor, g	give full name of parent or guard	lian						
4. What is you	ur occupation outside your sport	s activities?						
5. Name of Er	mployer							
Address								
	Number & Street		City	Province	F	Postal Code		
6. Name of Te	eam for which you were playing			7. Type of Sport				
8. Date of Accident D M Y 9. Where did accident occur?								
10. Describe i	in detail how accident occurred							
11. Was it du	uring an approved:   practice	☐ game ☐ travelling	12. Where	e was practice or game taking pla	ace?			
13. Date first	treated by dentist D	<u>M</u> Y						
14. Name of D	Dentist							
Address								
	Number & Street		City	Province	ſ	Postal Code		
, ,	of other dentist(s) who treated yo	ou			_			
	in hospital, Name of Hospital				D	M	Υ	
-	ave coverage for any dental expe	_	al, Medical or Dental F					
	an Name			Policy N				
I certify to t	the best of my knowledge	that the statements m	ade above are tr	ue, correct and complete.				
			(	)	D	М	Υ	
Claimant's Sig	nature (or signature of Parent or G	Guardian if Claimant is a minor)	Teleph	none Number	Date			
Complete Add	ress Number & Street		City	Province		Postal Code		
		s acceptance is not an admis	•	company or a waiver of any cor				
Club Secti				Policy Number				
Name of Te	eam		Name of Leag					
3. What sport			4.	What date did player join team	D	М	Υ	
5. Was the pla	ayer a regular member at time o	finjury?  Yes  No						
6. Was the player injured doing an approved activity? ☐ Yes ☐ No If Yes, an approved ☐ practice ☐ game ☐ travelling								
Authorized Sig	gnature	Print Name		Official F	osition/	Title		
Authorized Sig	gnature	Print Name			osition/	Title		
	gnature		City		osition/	Title Postal Code		

## **Proof of Loss – Accidental Dental (Sports Insurance)**

Ρ	aq	е	2

Part 1 – Dentist				Policy No.:								
Unique No.								Patient's 0	Patient's Office Account Number			
Patient's Name									I hereby assign any benefits payable from this claim to the named dentist and authorize			
Address				Address					lirectly to him/h		utilonze	
								Cian at ma	of Cubarribar			
Telephone N	o: <u>(</u> )			Telephone No:				Signature	Signature of Subscriber			
For Dentist (for additiona procedures o	Duplicate for											
									For Carrier Use :			
Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's	Fees	Laboratory Charges	Total Charges	Allowed Amount	Inc.	%	Patient's Share	
								Cheque No.		D	Date (D/M/Y)	
								Deductible	Patient Pays	PI	an Pays	
This is an accurate statement of services performed and the total fee due and payable, E & OE.					l fee	Total Fee Submitted : Claim Nu \$			<u>[</u> r			
Part 2 – Dentist's Supplementary Report												
Description of damage												
2. Is further treatment indicated?								nent (D/M/Y)				
					·····							
Describe further potential problems and indicate time frame.												
4. A) How many teeth were injured?  B) Were these whole or sound teeth?  Yes  No C) How many of these teeth had fillings?  D) How many of these injured teeth had crowns?  E) How many of these injured teeth had root canal treatment?												
F) If not whole or sound teeth, explain reason why  Dentist's Signature  Date D M Y												