5800 Explorer Drive, Suite101
Mississauga, ON L4W 5K9
905-602-9339 or 800-753-2632
Fax: 905-602-9141
www.kandkcanada.com
K&K Insurance Brokers, Inc. Canada

ONTARIO BASKETBALL ASSOCIATION INCIDENT REPORT

Time and Place of Incident:
Date: _____ Time: _____ ❑AM ❑PM
Event: _____
Sanctioned by: _____ Location: _____

Happened To:
Name: _____
Age: _____ Sex: ❑Male ❑Female Phone: (_____) _____
Address: _____
City: _____ Province: _____ Postal Code: _____

Function:
As: ❑Participant ❑Volunteer ❑Spectator ❑Bystander ❑Official
❑Other: _____

Apparent Injury or Damage:
Body Part: _____
Condition: (Laceration, Concussion, Sprain, Fracture etc.): _____
❑On-Site Care ONLY, by: ❑Physician ❑EMT ❑Trainer ❑Other: _____
❑Ambulance, taken to: _____ City: _____
❑Fatality

Occasion
What was the situation and exact location at the time of the incident? _____
_____
_____

Incident Description:
Describe what happened: _____
_____
_____

Witnesses:
Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: (_____) _____ Phone: (_____) _____

Insured:
Name of Insured: _____ Policy Number: _____
Club Name: _____ City/Prov: _____

Coach/Official/Team or League Representative:
Name: _____ Phone: (_____) _____
Title: _____ Organization: _____
Signature: _____ Date: _____

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

ACCIDENT MEDICAL INSURANCE CLAIM FORM

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED

OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER HEALTH & ACCIDENT INSURANCE AVAILABLE. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL. IF THERE IS NO OTHER INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. NOTE: COVERAGE MAY ALSO INCLUDE A POLICY DEDUCTIBLE.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON: _____

FATHER'S NAME (if injured is a minor): _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

PHONE: (_____) _____

GROUP INSURANCE COMPANY: _____

POLICY NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

SIGNATURE: _____

SPOUSE'S NAME (if applicable): _____

MOTHER'S NAME (if injured is a minor): _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

PHONE: (_____) _____

GROUP INSURANCE COMPANY: _____

POLICY NUMBER: _____

INSURANCE COMPANY ADDRESS: _____

CITY: _____ PROV: _____ PC: _____

SIGNATURE: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY MY CLAIM.

SIGNATURE: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian