2001 McGill College Avenue, Suite 2200, Montreal, Quebec H3A 1G1
T. 514-843-3632 | 1-800-465-2842 F. 514-843-3842

SPORT ACCIDENT CLAIM FORM INSTRUCTIONS 2025

ALL INCIDENTS SHOULD BE REPORTED AS SOON AS PRACTICABLE

- **Report the Incident** - BFL must receive notification of your accident within 30 days of it occurring and receive your claim form within 90 days of the accident.

- **Provide Documentation** - Complete attached Sport Accident Claim Form and Physician Statement. If your claim is for dental injury;
    - have your dentist complete and submit a Predetermination Form.

- **Submit Forms** - As noted on the attached claims from, please forward completed **ATHLETIC ACCIDENT CLAIM FORM** along with a copy of expense receipts, to Markel.
    - **Please provide a copy to BFL**
        - Email- josiannemoniz@bflcanada.ca
        - Mail - **BFL CANADA Risk and Insurance Services Inc.**
          Attention: Josianne Moniz
          2001, avenue McGill College, bureau 2200
          Montréal, Québec H3A 1G1

See Full INSTRUCTION page attached.

CLAIMS REPORTING INSTRUCTIONS :	
New claims that occur outside of business hours and require immediate assistance, please call 1-800- 465-2842	
Sport Accident Claim Contact • Josianne Moniz • Lorne Vaincourt	**Email:** • josiannemoniz@bflcanada.ca • lvaincourt@bflcanada.ca

BFL CANADA

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CANADIAN CYCLING ASSOCIATION

ATHLETIC ACCIDENT CLAIM FORM

SECTION 1 (PLEASE PRINT)

Last Name of Claimant:		First Name:	
Birth Date:		*Email:*	
Mailing Address:			
City:		Province:	Postal Code:
If Minor, Name of Parent:			
Contact Person if claiming is a minor (Parent or guardian):			
Home Telephone:		Business Phone:	

SECTION 2

Date of Accident:		Time:		☐ A.M.	☐ P.M.
Location of the Accident:					
What is the Injury?					
Date of First Treatment:		*Name of the hospital taken to:*			
Date of Admittance:		Time:		☐ A.M.	☐ P.M.
Date of Discharge:		Name of Attending Physician or Dentist:			

SECTION 3

Describe fully how the accident happened:

SECTION 4

(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:		Province:	Postal Code:
Policy No.:		Certificate Number:	

SECTION 5

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

Claimant's / Guardian's Signature:		Date:	

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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 claimant's registration current and in good standing when the injury occured? ☐ Yes ☐ No

Was the player injured while taking part in an authorized activity? ☐ Yes ☐ No

Name	Position with Club

Telephone No.:		Signature:	

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

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INSTRUCTIONS

You must provide all information requested; incomplete forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Your insurer must receive notice of your accident within 30 days of the accident date and receive claim documentation within 90 days.

2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
   - Patient's name
   - Type of purchase or service
   - Date of each purchase or service
   - Amount charged for each purchase or service

3. A physician statement confirming diagnosis and recommended treatment is required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible specified in your plan will be considered for payment up to your maximum benefits.

5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sport accident policy will pay only the amount of expenses that are not eligible with any other insurer.

- IF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:
  (Please check your plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

- FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

A. PRESCRIBED DRUGS
- Name of medication or drug
- Date of purchase
- Amount charged

B. SERVICES OF PHYSIOTHERAPIST, CHIROPRACTOR, OSTEOPATH
- Physician referral
- Type of service
- Date of each treatment
- Amount charged for each treatment

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- Date of treatment paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION
- Not an eligible expense

D. AMBULANCE (Emergency to Hospital only)
- Date of service
- Places ambulance taken from and to
- Amount charged

E. VISION CARE
- If your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
- An explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY
- If your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable
- A statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES
- A letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed must be submitted with your receipt
- Medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS
- Exact date of accident
- Breakdown of services performed
- Circumstances surrounding the accident
- Is there other dental coverage? Enclose details.
- Confirmation that treatments only relate to the accident
- Provide other insurer's explanation
- Are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
- Your Sport Accident Policy does not make payment for any services or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not

YOUR SPORT ACCIDENT POLICY MAY INCLUDE A DEDUCTIBLE AND/OR PERCENTAGE OF REIMBURSEMENT.
(Example: $100 deductible or $30 per treatment up to $300 per accident.) IF IN DOUBT, CHECK YOUR PLAN DETAILS.

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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	**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.

This is an accurate statement of services performed and fees charges. E. & OE.	**Total Submitted Fee**	
Dentist's Signature	**Date:**	
FOR DENTIST'S USE ONLY.		
For additional information Re: diagnosis, procedures or complications and special considerations.		

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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.	I hereby assign benefits payable from this claim to the above-named dentist and authorize payment directly to him.	CLAIM APPROVED:
Signature of Patient (or Parent/Guardian)	**Signature of Subscriber**	Day Month Year Assessor

PART 2 DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage:	
2. Is further treatment indicated?	☐ Yes ☐ No 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:		Dentist's Signature:	

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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:			