

All accidents must be claimed through personal insurance first and then the remaining balance can be applied for through the attached SRA Insurance Representative. Receipts must be attached to application.



**NOTIFICATION OF CLAIM  
ATHLETICS GROUP DEPARTMENT**



Full name of insured person \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of birth (D/M/Y) \_\_\_\_\_

If a minor, give full name of parent or guardian (relationship) \_\_\_\_\_

Name of team or league for which you were playing \_\_\_\_\_ Sport \_\_\_\_\_

Date of injury \_\_\_\_\_ Date first treated by dentist (if applicable) \_\_\_\_\_

Explain, in detail, how the accident occurred? \_\_\_\_\_

Was it during a practice period of playing a league game? \_\_\_\_\_ Where game or practice was taking place \_\_\_\_\_

Nature of injury \_\_\_\_\_

Name of dentist or doctor \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

What other hospital, medical or dental insurance do you have? \_\_\_\_\_

Signature of insured or guardian \_\_\_\_\_ Date \_\_\_\_\_ Telephone number \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

**CERTIFICATE OF TEAM MANAGER OR CLUB EXECUTIVE**

SASKATON RINGETTE ASSOCIATION \_\_\_\_\_ GROUP POLICY # 9027681 \_\_\_\_\_  
Name of Team/League/Association \_\_\_\_\_ Policy number or certificate number \_\_\_\_\_

RINGETTE \_\_\_\_\_  
What sport is team engaged in? \_\_\_\_\_ Was he/she injured while playing in a league game or in a practice \_\_\_\_\_  
YES \_\_\_\_\_

Was the above player a member at the time of injury? \_\_\_\_\_ On what date did he/she join the team? \_\_\_\_\_

Signed \_\_\_\_\_ State position in club \_\_\_\_\_ Telephone number \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

**Please send this document to :**

**B.F. LORENZETTI & ASSOCIATES INC.**  
Place Mercantile, 2001 McGill College, Suite 2200  
Montreal, Quebec, H3A 1G1

Ringette Club's name: \_\_\_\_\_

## OTHER INSURANCE DECLARATION FORM

The insurance Policy as purchased by your sports organization provides for coverage in excess of any private or government medical/dental plan. If you incur medical or dental expenses as the result of a sports injury, you are required to submit those expenses to your government or private medical/dental plan, firstly.

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts of expenses not covered to your sports association for processing.

Please clarify your situation by checking one of the following:

\_\_\_\_\_ Yes, I have private coverage and will be submitting my claim directly to my private insurers.

\_\_\_\_\_ Yes, I have private coverage but I do not believe that they will provide full reimbursement and would ask that you keep my claim open until we receive clarification of the amount of expenses not covered by them, at which time I will forward the amount not covered by them to you for your consideration.

\_\_\_\_\_ No, I do not maintain any medical/dental coverage. The expenses I am submitting are not covered by any other plan.

If you are a minor, then your parents or legal guardian must complete this form on your behalf.

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Please Print)

Signature: \_\_\_\_\_

**\*\*This form is to be submitted with every sports accident claim form, duly completed and signed.\*\***