



Return to:
C/o BFL CANADA Risk and Insurance Inc.
 2001 McGill College Avenue, # 2200
 Montreal, QC, H3A 1G1
 Tel: 514-843-3632 F: 514-843-3842 1-800-465-2842
claims@BFLcanada.ca | www.BFLCANADA.CA



AIG Insurance Company Of Canada
 145 Wellington Street West
 Toronto, ON M5J 1H8
ahclaimscan@aig.com

Accident Claim Form

IMPORTANT: This claim form must be **validated** by your Association (section on reverse). Once the claim form is complete and original itemized invoices attached, mail to BFL Canada within 30 days following the accident.

Insured's Surname: _____ Insured's Given Name: _____

Address: _____ Telephone No. (daytime): _____
 Email: _____

City/Town: _____ Province: _____ Postal Code: _____

Date of Birth (M/D/Y): _____ Sex: Male Female

1. Date of Accident (M/D/Y): _____ Date of Initial Medical attention (M/D/Y): _____

2. Location and full details of accident and nature of injury sustained: _____

3. Name of Company who carries your Group Hospital or Medical Insurance: _____

4. Name and address of Family Physician: _____

5. Name and contact information of witness to this accident: _____

6. Name and address of Surgeons or Specialists who provided treatment regarding this accident: _____

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada.

AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Name of Insured's Parent/Guardian (if under age 18 - print please): _____

Signature of Insured or Insured's Parent/Guardian (if under age 18): _____

Date (M/D/Y): _____

PHYSICIAN'S STATEMENT

Name of Patient: _____

Full description of injury sustained: _____

Date of First Attendance (M/D/Y): _____ Date of Actual Loss (M/D/Y): _____

Is loss permanent and irrecoverable? Give degree of loss: _____

Is condition direct result of an accident? Yes No

Did any disease or previous injury contribute to loss? Yes No If yes, describe: _____

Was Patient hospitalized? Yes No If yes, give Hospital Name and Address: _____

Names and Addresses of other Physicians or Surgeons, if any, who attended Patient:

Are you related to or in a business relationship with this patient? Yes No

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (please print) : _____

Address: _____

Signature of Attending Physician: _____ Date (M/D/Y): _____

Phone Number: _____ Fax Number: _____

ASSOCIATION STATEMENT

Name of Individual: _____ Name of Club: _____

The Individual is: Member Volunteer

Was the individual a member or volunteer on the date of the accident? Yes No

Did the injury occur while Insured was participating in an activity recognized by the Association? Yes No

Please attach a copy of your incident report related to this event (if available).

Signature: _____ Date (M/D/Y): _____

Title: _____ Phone Number: _____ Email: _____

The furnishing of forms shall not be an admission of liability by the Company.