



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 attached their payment statement(s).

Note – This form can be completed in ink (please print), however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned to **AXA Assurances Inc.** at any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5
2020 University Street, Suite 700, Montreal, Quebec H3A 25A
645 – 7th Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Claimant's Statement

Policy Number **9226251 Players**

1. Insured Member's Full Name _____ 2. Date of Birth D _____ M _____ Y _____

3. If a minor, give full name of parent or guardian _____

4. What is your occupation outside your sports activities? _____

5. Name of Employer _____

Address _____

Number & Street _____ City _____ Province _____ Postal Code _____

6. Name of Team for which you were playing _____ 7. Type of Sport _____

8. Date of Accident D _____ M _____ Y _____ 9. Where did accident occur? _____

10. Describe in detail how accident occurred _____

11. Was it during an approved: practice game travelling 12. Where was practice or game taking place? _____

13. Date first treated by dentist D _____ M _____ Y _____

14. Name of Dentist _____

Address _____

Number & Street _____ City _____ Province _____ Postal Code _____

15. Name(s) of other dentist(s) who treated you _____

16. If treated in hospital, Name of Hospital _____ 17. Date treated D _____ M _____ Y _____

18. Do you have coverage for any dental expenses under any other Hospital, Medical or Dental Plan? Yes No

If Yes, Plan Name _____ Company _____ Policy Number _____

I certify to the best of my knowledge that the statements made above are true, correct and complete.

Claimant's Signature (or signature of Parent or Guardian if Claimant is a minor) Telephone Number _____ Date D _____ M _____ Y _____

Complete Address _____

Number & Street _____ City _____ Province _____ Postal Code _____

The furnishing of this form or its acceptance is not an admission of liability by the company or a waiver of any conditions of the policy.

Club Section

Policy Number **9226251 Players**

1. Name of Team _____ 2. Name of League or Association **N.B. Interscholastic Athletic Assoc.**

3. What sport is team engaged in? _____ 4. What date did player join team D _____ M _____ Y _____

5. Was the player a regular member at time of injury? Yes No

6. Was the player injured doing an approved activity? Yes No If Yes, an approved practice game travelling

Authorized Signature _____ Print Name _____ Official Position/Title _____

Complete Address _____

Number & Street _____ City _____ Province _____ Postal Code _____

Telephone Number () _____ Date D _____ M _____ Y _____

