

PHYSICIAN'S STATEMENT

Physician _____ Address _____ Telephone () _____

Name of hospital/clinic _____ Address _____

Nature of injury: _____ Date of first attendance _____ DD / MM / YY

_____ Claimant will be totally disabled:

_____ From DD / MM / YY To DD / MM / YY

Is the injury permanent and irrecoverable? No Yes

Give details of injury (degree): _____

Prognosis for recovery: _____

Did any disease or previous injury contribute to the current injury? No Yes (describe): _____

Was claimant hospitalized? No Yes (give hospital name, address and date admitted): _____

Names and addresses of other physicians or surgeons, if any, who attended claimant: _____

I certify that the above information is correct to the best of my knowledge

Signed _____ Date DD / MM / YY

DENTIST'S STATEMENT							Limits of coverage: \$1,000 per tooth, \$2,000 per accident • Treatment must be completed within 52 weeks of accident								
P A T I E N T	LAST NAME				UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.				I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.						
	GIVEN NAME				D E N T I S T										
	ADDRESS APT.								Telephone						
	CITY PROV. POSTAL CODE				Signature of Subscriber										
FOR DENTIST'S USE ONLY FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.				I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.											
				I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.											
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.							_____ SIGNATURE OF (PATIENT/GUARDIAN)								
DUPLICATE FORM <input type="checkbox"/>				OFFICE VERIFICATION											
DATE OF SERVICE DD / MM / YY	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE									
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE. NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.						TOTAL FEE SUBMITTED									

Mail completed form to:
 Burlington Lions Optimist Minor Hockey Association, 3455 Fairview Street, Burlington, ON L7N 2R4