

# ACCIDENT CLAIM FORM

2011 Dubloon Ct, Ste 200  
 Edwardsville, IL 62025-5224  
 Phone: 314-255-2882  
 Fax: 888-849-2882

<b>SECTION I</b> (please print)		
Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone ( )	Business Phone ( )	

<b>SECTION II</b>		
Date of Accident	Hour	a.m./p.m.
Location of Accident		
What is the Injury?		
Date of First Treatment		
Name of Hospital taken to		
Date of Admittance	Hour	a.m./p.m.
Date of Discharge	Attending Physician or Dentist	

<b>SECTION III</b>	Describe fully how the accident happened.

<b>SECTION IV</b> (this 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	
City	Prov.	Postal Code	Policy No.
			Certificate

<b>SECTION V</b>	
I hereby certify that all the information provided above is correct.	
Claimant's / Guardian Signature	Date

Send completed form along with any invoices for expenses you had to pay yourself to: EXPERIENCING IMAGINATION 7060 Prarietown Rd, Edwardsville, IL 62025. (P): 314-255-2882 (F): 618-692-0014, (Email): info@TheEventLine.com. Please do not hesitate to email or call if you have any questions regarding this form. Instructions are on the reverse side. If you do not have costs at this time, please forward the form only and confirm that you intend to make a claim.

<b>CERTIFICATION OF EVENT HOST</b>	
Do not complete this section yourself; have the host organization of the event you attended complete this section.	
Host Name:	Event Contract ID#:
Address, City, St, Zip:	
Was the person above authorized to use equipment at the time of injury? Yes/No	
Is the signed waiver required for participation on hand? Yes/No	
Name	Position with Host
Telephone No.	Signature

# INSTRUCTIONS

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

## IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Initial notice of your accident must be received within 30 days of the accident date, and claim documentation must be received 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 treatments is required if you are claiming other than dental or ambulance expense.
4. Only claims in excess of the deductible, specified in your plan details, 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 sports 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
- dates of treatments paid by any 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

- this Accident Policy does not make payment for any service or treatment that is available from another source of payment or at a reduced cost except as such savings are included and deducted herein.

**NOTE: THIS ACCIDENT POLICY INCLUDES A \$5,000 DEDUCTIBLE THAT MUST BE PAID BY YOUR EVENT HOST (THIS IS NOT EXPERIENCING IMAGINATION).**



# 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: \_\_\_\_\_