HOLMAN
INSURANCE BROKERS LTD.

3100 Steeles Ave. East, Suite #101,
Markham Ontario Canada L3R 8T3

Website: www.holmanins.com
Telephone: 905-886-5630
Toll Free: 1-800-567-1279
Fax: 905-886-5622
E-mail: service@holmanins.com

Insurance and Risk Management Services provided for:

CyclingCANADACyclisme

Canadian Cycling Association – Sport Accident Claim Form 2013

MEMBER INFORMATION

Full Name of Insured Person (member): _____

Membership # _____ Affiliated Club Name: _____

Date of Birth (mm/dd/yyyy): _____ ☐ Male ☐ Female

Mailing Address including City and Postal Code: _____

Contact Person if claimant is a minor (parent or guardian): _____

Home Telephone:	Cell Phone Number:	Email address:

Date of Accident: _____ Time of Accident: _____ Location of Accident: _____

Name of Sanctioned Event or Activity: _____

Describe in detail how the accident occurred:

Type of Injury: _____

Name of Doctor/Dentist: _____

Address of Doctor/Dentist: _____

Do you have other benefits provided under any other insurance plan? ☐ Yes ☐ No (if "YES", please provide name of Insurer and policy number (certificate):

I hereby certify that all information provided in this accident form is correct.

Claimant/Guardian signature: _____ Date: _____

AFFILIATE INFORMATION

Certificate of Affiliated Canadian Cycling Club Executive:

Name of Team/League Association: _____

Was the player a member at the time of the accident? _____

Was the injury during a sanctioned event or activity? _____

SIGNATURE By signing this form you are consenting to the statements above.

Title:

Name (please print) _____

Signature: _____ Date: _____

HOLMAN
INSURANCE BROKERS LTD.

3100 Steeles Ave. East, Suite #101,
Markham Ontario Canada L3R 8T3

Website: www.holmanins.com
Telephone: 905-886-5630
Toll Free: 1-800-567-1279
Fax: 905-886-5622
E-mail: service@holmanins.com

Insurance and Risk Management Services provided for:

CyclingCANADACyclisme

Canadian Cycling Association

Physician's Statement

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician Statement.

Name of Patient: _____

Date of Birth (mm/dd/yyyy): _____ Male / Female: _____

Mailing Address: Street City Postal Code:

_____

Date of first visit: _____

Complete description of the injury and your diagnosis:

_____

_____

If hospital was required, give name of facility: _____

Date admitted: _____ Discharge date: _____

Name of referring physician, if any:

Physician Name: _____

Physician Address: _____

Physician Telephone #: _____

_____ _____ _____

Physician Signature: RCPS ID# Date: