



# CLAIM PROCEDURES

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POLICY NUMBER: 9226694

POLICY NAME: JUDO CANADA

CLAIM FORMS ARE TO BE COMPLETED BY THE INSURED AT THE LOCAL JUDO BRANCH AND FORWARDED TO JUDO CANADA IN OTTAWA FOR CONFIRMATION OF MEMBERSHIP. JUDO CANADA OTTAWA WILL IN TURN SEND THE FORMS ONTO:

AXA Assurances Inc.  
Suite 1400, 645 – 7<sup>th</sup> Avenue S.W.  
Calgary, Alberta T2P 4G8  
Attention: Accident & Sickness Claims

Should any questions arise pertaining to the claim, we will be in contact directly with the Insured.

PLEASE VISIT OUR WEBSITE AT [www.axa.ca](http://www.axa.ca) FOR ADDITIONAL CLAIM FORMS.

IF YOU REQUIRE ASSISTANCE, PLEASE CONTACT CINDY COLLIER AT AXA AT 1-800-665-8592.

THANK YOU FOR YOUR CO-OPERATION,

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**NOTE: CLAIMS THAT ARE SUBMITTED MORE THAN ONE YEAR AFTER THE DATE OF INJURY WILL NOT BE CONSIDERED.**

**AXA ASSURANCES INC.**

645-7th Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8  
Telephone : 403 261-3100, Fax : 403 261-3101



# Consent to collect, use and disclose personal information

## (Accident and Sickness Claims)

I authorize AXA Assurances Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for AXA Assurances Inc.;

for the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by AXA Assurances Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at AXA Assurances Inc. offices. Within AXA Assurances Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer  
AXA Assurances Inc.  
2020, University Street  
Suite 700  
Montréal, Québec H3A 2A5

This consent shall be valid for the length of time necessary for AXA Assurances Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving AXA Assurances Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in AXA Assurances Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

Date of the occurrence      D      M      Y Cause (accident, illness, etc.): \_\_\_\_\_

Signature of Insured \_\_\_\_\_ Print Name \_\_\_\_\_ Policy Number **9226694**

Date      D      M      Y Telephone (      ) \_\_\_\_\_

Address \_\_\_\_\_  
Street & Number \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Where the claim is for the Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

Signature of Authorized Representative \_\_\_\_\_ Print Name \_\_\_\_\_ Date      D      M      Y

Relationship to the Insured: \_\_\_\_\_

The completed authorization can 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 2A5**  
**645 – 7<sup>th</sup> Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8**



**Attending Physician Statement Section**

1. Patient's Name \_\_\_\_\_ 2. Patient's Age \_\_\_\_\_

Diagnosis of present condition \_\_\_\_\_

(a) Primary \_\_\_\_\_

(b) Secondary (if applicable) \_\_\_\_\_

4. On what dates did you examine the patient? D M Y D M Y D M Y

5. To the best of my knowledge

(a) Symptoms first appeared or accident happened D M Y

(b) Patient has had same or similar condition?  Yes  No

If "Yes", state particulars \_\_\_\_\_

6. If attended at hospital, name of hospital \_\_\_\_\_

Admitted D M Y Time \_\_\_\_\_ AM/PM

Discharged D M Y Time \_\_\_\_\_ AM/PM

7. If surgery performed, describe \_\_\_\_\_

8. If patient referred to you, give name of referring physician \_\_\_\_\_

9. Have you referred the patient to a specialist for additional treatments?  Yes  No

If "Yes", please explain \_\_\_\_\_

10. Have you referred the patient for physiotherapy treatments?  Yes  No If yes, date such referral was made: D M Y

Frequency and duration of physiotherapy treatments? \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Address Street City Province Postal Code

Telephone ( ) \_\_\_\_\_ Date D M Y

*The patient is responsible for securing this form and for any charges made for its completion.*



# 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 – 7<sup>th</sup> 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 9226694

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      (      )      D      M      Y Date

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 \_\_\_\_\_

1. Name of Team \_\_\_\_\_ 2. Name of League or Association \_\_\_\_\_

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

