

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:

Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7
2020 University Street, Suite 700, Montreal, Quebec H3A 25A
220 - 12th Avenue S.W., suite 600, Calgary (Alberta) T2R 0E9

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

Claimant's Statement

Policy Number _____

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 _____

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 _____

Proof of Loss – Accidental Dental (Sports Insurance)

Part 1 – Dentist		Policy No.: _____
Unique No. _____	Spec. _____	Patient's Office Account Number _____
Patient's Name	Dentist's Name	I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of Subscriber
Address _____	Address _____	
Telephone No: () _____	Telephone No: () _____	

For Dentist use only Duplicate form
 (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 (parent / guardian) _____

Office Verification _____

							For Carrier Use :			
Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	Total Charges	Allowed Amount	Inc.	%	Patient's Share
This is an accurate statement of services performed and the total fee due and payable, E & OE.							Total Fee Submitted :	Cheque No. _____		Date (D/M/Y) _____
							\$ _____	Deductible	Patient Pays	Plan Pays
								Claim Number _____		

Part 2 – Dentist's Supplementary Report

1. Description of damage _____

2. Is further treatment indicated? Yes No If **Yes**, please indicate :

Intl. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)
3. Describe further potential problems and indicate time frame. _____

4. A) How many teeth were injured? _____ B) Were these whole or sound teeth? Yes No C) How many of these teeth had fillings? _____
 D) How many of these injured teeth had crowns? _____ E) How many of these injured teeth had root canal treatment? _____

F) If not whole or sound teeth, explain reason why

Dentist's Signature _____

Date D M Y