



# HOCKEY CANADA INJURY REPORT



**CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Yr.

**INJURED PARTICIPANT:**  Player  Team Official  Game Official  Spectator  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: (M) (F)  
Mo. Day Yr.

Address: \_\_\_\_\_ City / Town: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

*Forms must be filled out in full or form will be returned. This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity*

**DIVISION:**

- Initiation  Novice  Atom  Peewee
- Bantam  Midget  Juvenile  Junior

**CATEGORY:**

- AAA  AA  A  B  BB  C  CC
- D  DD  E  House  Major Junior  Minor Junior
- Senior  Adult Rec.  Other \_\_\_\_\_

**BODY PART INJURED: \* visit the Hockey Canada web-site for an optional questionnaire \***

- |   |                                |                                  |                                    |  |                                |                                |                               |                               |                                |
|---|--------------------------------|----------------------------------|------------------------------------|--|--------------------------------|--------------------------------|-------------------------------|-------------------------------|--------------------------------|
| <b>Head</b>   | <b>Back</b>                    | <b>Trunk</b>                     | <b>Arm</b>                         | <input type="checkbox"/> Left          | <input type="checkbox"/> Right | <b>Pelvis</b>                  | <b>Leg</b>                    | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Eye Area <input type="checkbox"/> Face | <input type="checkbox"/> Neck  | <input type="checkbox"/> Ribs    | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Hand/Finger   | <input type="checkbox"/> Hip   | <input type="checkbox"/> Thigh | <input type="checkbox"/> Foot |                               |                                |
| <input type="checkbox"/> Throat <input type="checkbox"/> Dental | <input type="checkbox"/> Upper | <input type="checkbox"/> Chest   | <input type="checkbox"/> Upper arm | <input type="checkbox"/> Forearm/Wrist | <input type="checkbox"/> Groin | <input type="checkbox"/> Knee  | <input type="checkbox"/> Toe  |                               |                                |
| <input type="checkbox"/> Skull                                  | <input type="checkbox"/> Lower | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Elbow     | <input type="checkbox"/> Collarbone    | <input type="checkbox"/> Shin  | <input type="checkbox"/> Other |                               |                               |                                |

**NATURE OF CONDITION:**

- Concussion  Laceration  Fracture  Sprain  Strain
- Contusion  Dislocation  Separation  Internal Organ Injury

**ON-SITE CARE:**  On-Site Care Only  Refused Care

- Sent to Hospital by:  Ambulance  Car

**INJURY CONDITIONS: Name of arena / location:** \_\_\_\_\_

- Exhibition / Regular Season**  **Playoffs / Tournament**  **Practice**  **Try-outs**  **Other**
- Warm-up  Period #1  Period #2  Period #3  Overtime # \_\_\_\_\_
- Dry Land Training  Gradual Onset  Other Sport  Other: \_\_\_\_\_

**Was the injured player in the correct league and level for their age group?**  Yes  No

**Was this a sanctioned Hockey Canada activity?**  Yes  No

**CAUSE OF INJURY:**

- Hit by Puck  Collision with Boards  Non-Contact Injury
- Hit by Stick  Collision on Open Ice  Collision with Opponent
- Fall on Ice  Checked From Behind  Collision with Net
- Fight  Blindsiding

**LOCATION:**

- Defensive Zone  Offensive Zone  Neutral Zone
- Behind the Net  3 ft. from Boards  Spectator Area
- Parking Lot  Dressing Room  Bench
- Other: \_\_\_\_\_

**WEARING WHEN INJURED:**

- Full Face Mask  Intra-Oral Mouth Guard
- Half Face Shield/Visor  Throat Protector
- Helmet/No Face Shield  No Helmet/No Face Shield
- Short Gloves  Long Gloves

**ADDITIONAL INFORMATION:**

- Has the player sustained this injury before?  Yes  No
- If "Yes" how long ago \_\_\_\_\_
- Was a penalty called as a result of the incident?  Yes  No
- Estimated Absence from hockey?  1 week  1-3 weeks  3+ weeks

**DESCRIBE HOW ACCIDENT HAPPENED: (Attach page if necessary)**

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photo static/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian if under 18 years of age)

**TEAM INFORMATION: (To be completed by a Team Official)**

Association: \_\_\_\_\_ Team Name: \_\_\_\_\_

Team Official (Print) \_\_\_\_\_ Team Official Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

**THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED**

Occupation:  Employed Full-time  Employed Part-time  Unemployed  Full-Time Student

Employer (If minor, list parent's employer): \_\_\_\_\_

- Do you have provincial health coverage?  Yes  No Province: \_\_\_\_\_
- Do you have other insurance?  Yes  No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
- Has a claim been submitted?  Yes  No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To:  Injured Person  Parent  Team  Other: \_\_\_\_\_

**Branch APPROVAL**

**PHYSICIAN'S STATEMENT**

Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_

Name of Hospital / Clinic: \_\_\_\_\_ Address: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_ Date of First Attendance: \_\_\_\_\_

\_\_\_\_\_ Claimant will be totally disabled:  
From: \_\_\_\_\_ To: \_\_\_\_\_

Is the injury permanent and irrecoverable?  No  Yes

Give the details of injury (degree): \_\_\_\_\_

Prognosis for recovery: \_\_\_\_\_

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

Was the 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 and the best of my knowledge,

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**DENTIST STATEMENT**

Limits of coverage: \$1,250 per tooth, \$2,500 per accident  
Treatment must be completed within 52 weeks of accident

		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
P LAST NAME	GIVEN NAME	D	
A _____		E	
T _____		N	
I ADDRESS	APT.	T	
E _____		I	
N _____		S	
T CITY	PROV.	PHONE NO.	SIGNATURE OF SUBSCRIBER _____
	POSTAL CODE	T	

FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION, DIANOGNIS 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 THE SERVICES RENDERED.  
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

DUPLICATE FORM

\_\_\_\_\_  
SIGNATURE OF (PATIENT/GUARDIAN)

**OFFICE VERIFICATION**

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CHARGE	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.	<b>TOTAL FEE SUBMITTED</b>
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NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

**Mail completed form to:**  
**Hockey Manitoba**  
**145 Pacific Ave, Winnipeg, MB R3B 2Z6**  
**Phone: (204) 925-5758**

### **When are you covered?**

1. Hockey Canada/Branch sanctioned events (league games, tournaments, practices, training camps, sanctioned fundraisers) when playing member teams only!
2. Transportation directly to and from the arena or venue.
3. Accommodations while billeted or at a hotel during a Hockey Canada/Branch sanctioned hockey activity.

### **Major Medical / Dental Coverage**

**Please refer to pages 21-33 of the “Safety for All” handbook for complete details of the Hockey Canada Insurance program including the policy limits.**

This insurance augments Provincial, Medical and Hospital plans. It covers players, coaches, referees and other designated volunteers against accidents that occur during participation in a Hockey Canada/Branch sanctioned activity.

This plan is designed to provide coverage for those who might otherwise not be covered by any other group health insurance plan. It can also serve as a supplement to other similar coverage an individual or family may hold, to achieve maximum allowable coverage. It is not applicable as an addition when another plan’s coverage meets or exceeds the allowable amount.

### **How to make a Claim**

1. **SECURE** a Hockey Canada Injury Report Form from your team or Minor Hockey Association. In the event that there are none available, contact Hockey Manitoba or download the form at [www.hockeymanitoba.mb.ca](http://www.hockeymanitoba.mb.ca) under the menu option ‘Insurance’.
2. **COMPLETE** the form in its entirety. Have your team official complete the team section and your Doctor/Dentist complete the back of the form.
3. **SUBMIT** the fully completed form to your Branch office (along with any receipts or invoices) **within 90 days of the date of injury**.

#### **NOTE:**

- Only Injury Report Forms received in the Branch office **within 90 days of the date of injury** will be accepted.
- Forms must be completed in their entirety or the forms will be returned.
- Only original receipts and/or invoices are acceptable (If originals have been forwarded to a primary insurer, copies are acceptable). **DO NOT FAX IN CLAIMS**
- Hockey Canada is **strictly a supplemental insurer**. If you have access to any other insurance, you must pursue your claim through them first. Hockey Canada shall cover those costs not covered by your primary insurance to our policy limits.
- For **all teams travelling to the USA** for sanctioned tournaments/games: All players **MUST** have some form of primary insurance to be eligible for Hockey Canada’s supplemental insurance
- To all teams acquiring players from the USA: all **USA players MUST have primary insurance coverage** to be eligible for Hockey Canada’s supplemental insurance.

**FOR FURTHER INFORMATION ON COVERAGE, POLICY LIMITS AND ADDITIONAL FEATURES OF THE INSURANCE PROGRAM, PLEASE CONTACT YOUR BRANCH OFFICE.**

**HOCKEY MANITOBA  
145 Pacific Ave.  
Winnipeg, MB R3B 2Z6**

**Ph: (204) 925-5758**

**Email: [info@hockeymanitoba.mb.ca](mailto:info@hockeymanitoba.mb.ca)**

[www.hockeymanitoba.mb.ca](http://www.hockeymanitoba.mb.ca)