OCEANIC UNDERWRITERS LTD.

INSTRUCTIONS

You must provide all information requested as follows:

IMPORTANT FACTORS TO CONSIDER WHEN COMPLETING YOUR CLAIM:

1. Your Insurer must receive the Notice of Accident within 30 days of the accident date, and receive claim documentation 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
   Date of each purchase or service
   Type of purchase or service
   Amount charged for each purchase or service

3. If you are claiming other than dental or ambulance expense, a physician statement confirming diagnosis and recommended treatments is required.

4. Only claims in exceeding the deductible, as 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 OTHER BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:

(Please check you 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 PROCEDUE

A. PRECRIPTION DRUGS
- name of medication or drug
- date of purchase
- amount charged

B. SERVICES OF PHYSIOTHERAPHIST, CHIROPRACTOR, OSTEOPATH
- physician referral
- type of service
- date of each treatment
- amount charged for each treatment
- date of treatments paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMODATION
- not an eligible expense

D. EMERGENCY TRANSPORTATION
- date of service
- places taken from and to
- amount charged

E. 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

F. 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

G. 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?

H. 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

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
- your Accident Medical Policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not

ACCIDENT MEDICAL CLAIM FORM

SECTION I (please print) Claimant's Surname	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone	Business Phone	Cell phone
Status (ie. Competitor, Official, etc.)		

SECTION II Date of Accident	Hour	AM/PM
Location of Accident		
Type of Injury		
Accident first notified by	Date	
First Aid provided by		
Nature of Treatment / Medication Given		
Name of Hospital attended		
Location of Hospital		
Date of Admittance	Hour	AM /PM.
Date of Discharge	Attending Physician or Dentist	
Date of First Treatment		

SECTION III Describe fully how the accident occurred (cause)
Weather conditions at the time of accident (if applicable)

SECTION IV (your Sportguard 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 Coverage Limits

CERTIFICATE OF ASSOCIATION OR LEAGUE EXECUTIVE
Do not complete this section yourself, have your Association or League President, Coach or Manager complete this section.

Name of Team	League or Association
Group Policy No.	Type of Sport
Was the above player a registered member at the time of injury? ☐ Yes/No ☐	
Was the player injured while taking part in an authorized activity? ☐ Yes/No ☐	
Name	Position with Club
Telephone No.	Signature

SECTION V
I hereby certify that all the information provided above is correct.

Claimant's / Guardian Signature	Date

Send complete from along with any invoices for expenses you had to pay yourself to: Oceanic Underwriters Ltd., 625 Howe Street, Suite 650, Vancouver, BC, V6C 2T6. Tel: 604-689-1501. Fax: 604-689-5663. Please do not hesitate to call Oceanic Underwriters Ltd. 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 claim.

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ATTENDING PHYSICIAN'S STATEMENT

Please complete this form and return it to your patient

Patient's Name: _____ Age: _____

Address: _____

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Date Discharged: _____

If referred to you, give name of referring physician:

_____

Operations (or other procedures performed):

_____ Date: _____

_____ Date: _____

_____ Date: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

_____

_____

_____

_____

_____

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 condition affecting the present condition?

_____

Date: _____ Signature: _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____

OCEANIC UNDERWRITERS LTD.

DENTAL FORM

PART 1 DENTIST

Dentist's Name			Patient's Surname		Given Names
Address			Address		
City	Province	Postal Code	City	Province	Postal Code
Telephone			Telephone		

Date of Service Day | Mo | Yr	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charged. E. & OE

Total Submitted Fee

Dentist's Signature

Date: Day Month Year

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FOR DENTIST'S USE ONLY.
For additional information RE: diagnosis, procedures, or complications and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Signature of Patient (or Parent/Guardian)

Signature of Subscriber

FOR PLAN ADMINISTRATOR USE ONLY :

NOTICE TO DENTIST:
Please Note – Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your co-operation will be appreciated.

CLAIM APPROVED:

Day Month Year Assessor

PART 2 DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage _____

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes", please indicate:

Int. Tooth Code		Treatment indicated – use procedure code if possible	Est. Date – Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame. _____

Date: Day Month Year _____ Dentist's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL