By Furnishing This form the Company Makes No Admission of Liability or Waiver of Its Rights. To Be Completed and Returned Within Fifteen Days.

BFL Canada INC.

Le Groupe de compagnies Lorenzetti/The Lorenzetti Group of Companies

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ACCIDENT CLAIM REPORT

GROUP POLICY HOLDER	NAME OF YOUR CLUB	POLICY NUMBER	CERTIFICATE NO.
SPORT NL		6300010	N\A
INSURED'S FULL NAME	STREET ADDRESS	CITY	PROVINCE
DATE OF BIRTH	HEIGHT AND WEIGHT	MARITAL STATUS	TELEPHONE
OCCUPATION PRIOR TO DISABLEMENT	DUTIES	MONTHLY EARNINGS	WEEKLY EARNINGS

1 Give Full description of injury or disease from which you are now suffering. If an injury, tell when, where and how it happened.

SICKNESS ☐
INJURY ☐

2 A Have you ever had this, or a similar condition, in the past?

B If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics

YES ☐ Condition(s): ______________________

NO ☐ Dates: ______________________

3 A Give exact date when illness began, or injury occurred. — **A** Date: ______________________

B When did you first consult a physician for this condition? — **B** Date: ______________________

C When did you become totally disabled (unable to work)? — **C** Date: ______________________

D When were you able to again perform part of your occupational duties? — **D** Date: ______________________

E When were you able to again perform all your occupational duties? — **E** Date: ______________________

F If still totally disabled, when do you expect your disability to terminate? — **F** Date: ______________________

	NAMES	ADDRESSES	FROM / TO
4 Hospitals (Give complete names, addresses and dates of confinement.)			
	NAMES	ADDRESSES	TELEPHONE
5 A Give names, addresses and telephone numbers of all attending physicians.			
B Give name, addresses and telephone numbers of usual family physician.			
	NAMES	ADDRESSES	BENEFITS
6 What other accident, sickness or disability insurance do you carry and what organizations or companies have paid you indemnity for sickness or injury?			
7 What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics).			
	NAMES	ADDRESSES	FROM / TO
8 Names and addresses of Employers and length of employment with each?			

I hereby authorize any hospital, physician or other person who has attended me, or any employer, to furnish Premiere Underwriting Services or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Approved by:

Dated ______________________

SIGN YOUR FULL NAME ______________________

____
Authorized Members Signature