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BFL Canada INC.

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ACCIDENT CLAIM REPORT

ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

ACCIDENT

GROUP POLICY HOLDER SPORT NL	NAME OF YOUR CLUB	POLICY NUMBER 6300010	CERTIFICATE NO. N/A
PATIENT'S NAME AND ADDRESS			AGE

<p>1 A Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location)</p> <p>B Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>2 A When did symptoms first appear or accident happen?</p> <p>B When did patient first consult you for this condition?</p> <p>C Has patient ever had same Or similar condition? If "Yes" state when and describe</p>	<p>Date _____ Year: _____</p> <p>Date _____ Year: _____</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3 A Nature of surgical or obstetrical procedure, If any (describe fully)</p> <p>B Charge to patient for this procedure including post-operative care</p> <p>C If performed in hospital, give name of hospital</p>	<p>Date performed _____ Year: _____</p> <p>\$ _____</p> <p>_____ Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/></p>
<p>4 Give dates of other medical (non-surgical) treatment, if any</p>	<p>Office _____</p> <p>Home _____</p> <p>Hospital _____</p> <p>Nursing Home _____</p>
<p>5 What other services, if any, did you provide patient? (Itemize, giving dates and fees)</p>	
<p>6 Where registered private duty nurse (R.N.) Services necessary?</p>	
<p>7 Is patient still under your care for this condition? If "No" give date your services terminated</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Date _____ Year: _____</p>
<p>8 A How long was or will patient be continuously totally disabled? (Unable to work?)</p> <p>B How long was or will patient be partially disabled?</p> <p>C Was house confinement necessary? If "Yes" give dates</p>	<p>From _____ Year: _____ Thru _____ Year: _____</p> <p>From _____ Year: _____ Thru _____ Year: _____</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> From _____ Year: _____ Thru _____ Year: _____</p>
<p>9 To your knowledge, does patient have other health insurance or Health plan coverages? If "Yes" identify</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	PROVINCE	POSTAL CODE