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Langley, BC V2Y0E7
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FAX: (604)888-1008
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E-mail: claims@sports-can.ca

ISLAND BREEZE NOTIFICATION OF CLAIM

Important

- In event of hospitalization, Mega Assistance must be notified prior to, or within 24-hours of admission to hospital, and prior to any surgery or invasive investigations being performed.
- All claims must be reported within 30-days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- This form must be completed by the Insured, or if a minor, by the legal guardian or parent.

Requirements

- Completed and signed claim form and Medical Certificate
- Claim form must be completed by the parent or legal guardian if the Insured is a minor.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatments received.

Agency where purchased

Policy No.

Name of Insured

Male/Female

Date of Birth D/M/Y

Name of Claimant (If other than above)

Relationship to Insured (if applicable)

If a Minor, give Full Name of Parent or Guardian (Relationship)

Address

City

Postal Code

Province/ State

Country

Date of Loss (Note all drug receipts must show patient name, drug name and drug identification number (DIN). If other medical or paramedical receipts should show provider name and address, all dates of visits and detailed related costs. Attach physician referral.

Explain, in detail; How the loss occurred?

Nature of Injury

Name of Dentist or Doctor

Address

Apt.

City

Province

Postal Code

Have you experienced this sickness of a similar problem before? _____ If yes, when and name and address of treating doctor? _____

Do you have any chronic sickness or disease? _____ If yes, please provide date diagnosed and describe condition / diagnosis? _____

Does the Claimant have medical insurance under any other plan?
(Including Spouse's insurance/government health plan)

Name of Insuring Agency

Please complete this form in its entirety, answering all sections and submit original bills to the above address. **Sports-Can Insurance Consultants Ltd.**

I authorize the release of any information requested in respect of this claim to the Insurer or its agents and certify that the information given is true, correct to the best of my knowledge

Signature of Claimant or Guardian

Date

OTHER INSURANCE DECLARATION FORM

The Policy you purchased provides coverage in excess of any private or government medical/dental plan. **If you incur medical or dental expense as the result of your loss, you are required to first submit those expenses to your government or private medical dental plan. Only expenses not covered by MSP (the provincial plan for province you reside in) will be considered. Any primary coverage you have in excess of the provincial plan must also be utilized first.**

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts *not paid* for processing.

Please clarify your situation by checking on of the following:

- Yes, I do have private coverage but I do not believe that they will provide full reimbursement and would ask that you keep my claim open until we receive clarification of the amount of the expenses not covered by them, at which time I will forward the amount not covered by them to you for your consideration.
- No, I do not maintain any private medical/dental coverage. The expenses I am submitting are not covered by any other primary plan.

If you are a minor, then your parents or legal guardian must complete this form on your behalf.

DATE: _____

NAME: _____
(Please Print)

SIGNATURE: _____

THIS FORM IS TO BE SUBMITTED WITH EVERY CLAIM FORM, DULY COMPLETED AND SIGNED.