



# Membership Card

## AXA Assistance Program

In the event of an emergency, **immediately** call:

**1 866 783-9473** (Toll free from U.S.A. and Canada)

**514 285-8195** (From outside U.S.A. and Canada,  
call collect via operator)

*Do not forget to dial the country code, then "1-514", before the telephone number.*

POLICYHOLDER'S CERTIFICATE  
Policy No. 9229118  
Pacific Coast Amateur Hockey Association

**Please complete the attached certificate and return to us.**

Eligible Person: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Canadian Address: \_\_\_\_\_

Claim is For: Player, Team Official, Volunteer, Parent or Sibling:

\_\_\_\_\_

Trip dates: \_\_\_\_\_

Trip location: \_\_\_\_\_

Was insured travelling directly to and from and participating in sanctioned activities/games  
in the United States of America?

\_\_\_\_\_

Signed By: \_\_\_\_\_

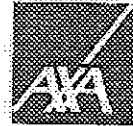
Print Name: \_\_\_\_\_

Official Position: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

# Emergency Medical Claim Report: Out-of-Province / Out-of-Country



Please answer all questions fully - it helps us to provide better service.

**Important:** In the provinces of Ontario, British Columbia, Alberta, Saskatchewan, New Brunswick and Quebec, claims can be submitted directly to AXA Assurances Inc. In all other provinces claims must be supported by a copy of the details of the claimant's provincial health plan and other insurance carriers' settlement or denial, and a copy of all ORIGINAL bills showing the date and details of services rendered.

It is important that all questions on this claim report be answered - if any section is not applicable indicate by n/a.

**Note:** This form can be completed in ink (please print), however, the form must be signed and dated and then the ORIGINAL, signed form in its entirety along with ORIGINAL medical receipts must be returned to AXA Assurances Inc. at any of the following addresses:

Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7

2020 University Street, Suite 700, Montreal, Quebec H3A 2A5

220 - 12th Avenue S.W., suite 600, Calgary (Alberta) T2R 0E9

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

## Insured Information

1. Insured Person's Full Name PCAHA
2. Date of Birth      D      M      Y
3. Policy Number 9229118
4. Employee Number
5. Claimant's Name
6. Relationship to Insured
7. Claimant's Signature
8. Date of Birth      D      M      Y
9. To be completed by Insured Employee who is claiming for his/her dependant children. (Please complete one claim form per child)  
 Is your dependant child married?  Yes  No Does he/she permanently reside with you?  Yes  No  
 Is he/she in attendance at University or College?  Yes  No If "Yes", give name and address of school
10. Employer's Name
11. Telephone No. ( )
12. Employer's Address

## Claim Details

1. Was this expense incurred while travelling on business?  Yes  No
2. Departure date from province      D      M      Y
3. Return date to province      D      M      Y
4. This claim is due to:  Injury  Sickness (Describe how and where it happened)
5. When did injury occur or symptoms of sickness first appear?      D      M      Y
6. Where did injury occur or symptoms of sickness were first noted (city/country)?
7. (a) Have you had same or similar condition before?  Yes  No If "Yes", provide details

**Emergency Medical Claim Report: Out-of-Province / Out-of-Country (continued)**

(b) Please provide names of physicians consulted for your previous condition:

Name \_\_\_\_\_ Address \_\_\_\_\_

Diagnosis \_\_\_\_\_ Consulted: From/To \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Diagnosis \_\_\_\_\_ Consulted: From/To \_\_\_\_\_

8. Were you hospitalized for your present condition?  Yes  No If "Yes", please provide the following:

Name and address of hospital: \_\_\_\_\_

Dates of hospital confinement

From D M Y to D M Y | From D M Y to D M Y

9. Name and address of your family doctor in Canada

Name \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Address \_\_\_\_\_

10. Is the claimant insured under a provincial health plan?  Yes  No - If "No", please provide an explanation

11. Does the claimant have any other health insurance?  Yes  No - If "Yes", please give name and address of company

Policy Number \_\_\_\_\_

Type of Coverage \_\_\_\_\_

**Schedule of Expenses**

(If space is insufficient, please continue on a separate sheet of paper)

Has Account Been Paid?		Name of Provider	Date of Service (D/M/Y)	Total Bill*	Do Not Write in This Space	Do Not Write in This Space	Paid By Provincial Health Plan	Paid by Other Insurance Carrier	Do Not Write in This Space
Yes	No								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<b>Totals</b>									

I certify to the best of my knowledge that the statements made above are true, correct and complete.

Insured's Signature \_\_\_\_\_ Date D M Y \_\_\_\_\_

Permanent Address \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Mailing Address \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.