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

AXA

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 dependent children. (Please complete one claim form per child)*
   Is your dependent 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? Yes	No	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
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
			Totals						

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.