



**LEAGUE INSURANCE POLICY  
ACCIDENT CLAIM FORM**

In the event of accidental injury to an insured person, this form should be completed (three copies) and forwarded without delay to Air Cadet League Headquarters, 201-1505 Laperriere Avenue Ottawa, ON K1Z 7T1. All claims must be reported within a period of 30 days from date of accident. For further information please call (613) 941-3739.

**TO BE COMPLETED BY CLAIMANT OR GUARDIAN**

Surname: \_\_\_\_\_ Given Name \_\_\_\_\_

Rank or appointment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: Male Female  
D M Y

Full details of the accident:

Nature of injuries

Whether slight or severe and probable duration of incapacity:

Has a doctor been in attendance? If so, give name and address:

If taken to hospital, state which, and whether an in-patient or out-patient: \_\_\_\_\_

Name of Officer or Instructor on duty: \_\_\_\_\_

If claiming for medical and other expenses, please give details below:

(a) Already incurred: \_\_\_\_\_

(b) Anticipated: \_\_\_\_\_

Please forward duplicate copies of all medical invoices whether received or otherwise.

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE.**

Signed \_\_\_\_\_ Date: \_\_\_\_\_  
(Guardian if under 18 years of age)

**TO BE COMPLETED BY OFFICER**

Cadet: \_\_\_\_\_ Cadet Unit: \_\_\_\_\_

Did this injury occur while participating in an approved Air Cadet activity? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Officer: \_\_\_\_\_

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

Squadrons are reminded that Air Cadet League insurance policy is designed to supplement, but not to replace, the medical benefits provided by the Canadian Forces and/or by Government Health Services Insurance. In cases of accident or injury, squadron Commanders are requested to follow the procedure outlined in QR & O, Chapters 34-35.

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

**MEDICAL/DENTAL AUTHORITY**

I hereby authorize any hospital, physician, dentist or other person who has attended or examined me to furnish to Insurance Company, any and all information with respect to any illness or injury, medical history, dental history, consultation, prescriptions or treatment and copies of all dental, hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

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

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

ACC30 (rev Feb 2015)

(Guardian if under 18 years of age)