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 1-877- I CAN FLY (422-6359)

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 receipted 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: _____

*** FORM WILL BE RETURNED IF NOT COMPLETED IN FULL ***
PLEASE HAVE REVERSE OF FORM COMPLETED BY DENTIST OR DOCTOR FOR ALL INJURIES

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 photastatic copy of this authorization shall be considered as effective and valid as the original.

Date:_____ Signed: _____

ACC30 (rev April 2020) (Guardian if under 18 years of age)