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)