The Navy League of Canada
National Office
305 Rideau Street
Ottawa ON K1N 9E5

Claims Procedure – Claims must be presented within 30 days from the date of injury. Please answer all questions in full and submit completed form with itemized original receipts to The Navy League of Canada, National Office.

TO BE COMPLETED BY CLAIMANT

Surname: _____ Given Name: _____

Complete Mailing Address: _____

_____

Date of Accident: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Full details of the accident:

_____

_____

_____

Nature of injury sustained:

_____

_____

_____

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

Signed _____ _____ _____

Claimant Witness Date

TO BE COMPLETED BY OFFICER

Cadet: _____ Cadet Corps: _____

Did this injury occur while participating during a sanctioned activity? ☐ Yes ☐ No

Name of Officer: _____

Address of Officer: _____

_____

Signed: _____ Date: _____

***** Form will be returned if not completed in full *****
Please have reverse of this 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 AON 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 photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ **Signed** _____

PHYSICIAN'S STATEMENT

Nature of loss: _____

Is loss permanent and irrecoverable? Give degree of loss. Claimant will be totally disabled

_____ From: _____ To: _____

Was injury described sufficient to produce total & permanent loss?

☐Yes ☐ No If yes, describe _____

What evidence of traumatism did you find? _____

Did any disease or previous injury contribute to the loss?

☐Yes ☐ No If yes, describe _____

Was claimant hospitalized?

☐Yes ☐ No If yes, Give hospital name, address and date admitted

_____

Name of physicians or surgeon who attended claimant.

_____

I certify that the above information is correct to the best of my knowledge.

Date: _____ Physician: _____

ATTENDING DENTIST'S STATEMENT

DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCT. NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT: LAST NAME | GIVEN NAME; ADDRESS | APT.; CITY | PROV. | POSTAL CODE

DENTIST: PHONE NO.

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.
I ACKNOWLEDGE THAT THE TOTAL FEE OF $ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) ►

OFFICE VERIFICATION

DUPLICATE FORM ☐

DATE OF SERVICE D M Y	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED: $