CYCLING BC

JONES BROWN

ACCIDENT DETAILS & MEDICAL REPORT FORM

Please complete all sections fully. All fields are compulsory.
Any incomplete fields may delay the processing of your claim.

NAME OF POLICY HOLDER	CYCLING BC	POLICY NO.	170/025711
NAME OF CLAIMANT			
IF A MINOR, GIVE FULL NAME OF PARENT OR GUARDIAN			
ADDRESS		DATE OF BIRTH	
CITY		CONTACT (Phone)	
POSTAL CODE		CONTACT (Email)	
ARE YOU A MEMBER OF CYCLING BC	☐ YES	☐ NO	
NAME OF TEAM OR CLUB FOR WHICH YOU WERE RIDING AT THE TIME OF THE ACCIDENT (If applicable)			
DATE AND TIME OF ACCIDENT		DATE FIRST TREATED BY DOCTOR (If applicable)	
EXPLAIN, IN DETAIL, HOW THE ACCIDENT OCCURRED?			
WAS THE ACCIDENT DURING A RACE OR CLUB TRAINING RIDE?	☐ YES ☐ NO	WHERE WAS THE RIDE TAKING PLACE	
WHAT WAS THE NAME OF THE EVENT THAT YOU WERE PARTICIPATING IN AT THE TIME OF THE ACCIDENT (If applicable)			
NATURE OF INJURY			

Please submit form to Cycling BC at membership@cyclingbc.net

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NAME OF DOCTOR		ADDRESS	
DOES THE CLAIMANT HAVE MEDICAL INSURANCE (HOSPITAL, MEDICAL, OR DENTAL) UNDER ANY OTHER PLAN? (Including Spouse's Insurance and/or government health plan)	☐ YES	☐ NO	
IF YES, PROVIDE POLICY NO.			

PLEASE PROVIDE A DIAGNOSIS FOR EACH BILL SUBMITTED		
DATE OF SERVICE	CHARGES	DIAGNOSIS/CONDITION/ILLNESS

HAS THE CLAIMANT EVER HAD SAME OR SIMILAR CONDITION	☐ YES	☐ NO	
If YES, STATE WHEN AND DESCRIBE			

I authorize the release of any information requested of this claim to the insurer or its agents and certify that the information given is true, correct, and complete to the best of my knowledge.

SIGNATURE OF CLAIMANT	
DATE	

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