Sagicor GENERAL
Wise Financial Thinking for Life

EIB INC. EMPIRICAL INSURANCE BROKERS INC.

SPORTS GROUP PERSONAL ACCIDENT CLAIM/INJURY FORM

IMPORTANT INFORMATION

This Claim/Injury Report Form should be used if you are an Athlete, Official or Administrator (Insured Person) of The Barbados Olympic Association Inc and/or Affiliated National Federations and whose name is currently included in the Bordereaux of Insured Persons.

Please ensure that this Claim Form is fully completed before submitting to us. Failure to do so will result in delay in processing your claim.

CLAIMANT'S DETAILS

Name in full (state: Mr Mrs Miss): _____

Date of Birth: _____

National Registration Number: _____

Occupation: _____

Name of Employer:_____

Home Address: _____

Telephone Numbers:_____Home_____Business_____Cell

Affiliated Association: _____

Club Name: _____

Athlete/Official/Administrator: _____

CLAIM DETAILS

1. The date and time of the Accident/incident: Date: _____time: _____
2. Place/location where the Accident/incident occurred: _____

   _____
3. Did the Accident/incident occur whilst the Athlete/insured person was:

   (a) Playing in a scheduled/arranged event: _____

   (b) Practicing or training:_____

   (c) Involved in other activities:_____
4. Full details of the how the Accident/incident occurred:_____

   _____

   _____
5. Please provide details of:

   (a) the injury sustained: _____

   (b) The diagnosis of the injury sustained: _____

   (c) Had to be hospitalized or seek medical attention: _____

   (d) Name of Hospital/Clinic and/or attending Physician:
   _____

   _____

   (e) Names of witnesses (if any): _____

   (f) Name of Coach: _____

   (g) Signature of Coach: _____

6. Attending Physician's Comments:

_____

_____

_____

_____

7. Has the athlete/insured person ever suffered injury to, or had treatment for, or had any abnormality to the injured body part? If so, please provide full details:

_____

_____

8. Does the Insured Person currently have any other medical plan? _____

   If "Yes", Please state
   Name of Insurance Company: _____

9. Kindly state name of person/association/federation to whom any claim payment is to be made.

   _____

DECLARATION

The undersigned declares that the information on the claims form and any attached documents, is correct and complete and that I have not withheld any information that could affect this claim. I understand that any false statement or information may lead to my claim being denied. I also understand and accept that until I provide all the required information, Sagicor General Insurance Inc will not be able to process my claim and will have no obligation to make any payment to me or on my behalf.

I authorize any hospital/clinic, physician or any other person(s) who has attended to me to furnish Sagicor General Insurance Inc with all information in respect of any sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical reports.

If Insured is under the age of 18 years, this form should be signed by a Parent /Guardian.

Signature of the Claimant: _____

Dated: _____

Please ensure that all medical bills are attached

For further information please contact:

Barbados Olympic Association
Olympic Centre
Garfield Sobers Complex, Wildey, ST. MICHAEL
BARBADOS BB15094

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Fax: 1-246-426-1998

Email: info@olympic.org.bb
Website: www.olympic.org.bb