LEAGUE INSURANCE CLAIM FORM

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 appropriate Cadet League 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 (use additional paper as required):

_____

_____

_____

Nature of injury sustained (use additional paper as required):

_____

_____

_____

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

Signed _____ _____ _____

Claimant Witness Date

TO BE COMPLETED BY OFFICER

Cadet: _____ Cadet Corps/Squadron: _____

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 the 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** _____