INJURY AT WORK PACKAGE

FOR ALL CASUAL EMPLOYEES, EMPLOYEES WITH CONTRACTS LESS THAN 16 HOURS AND EMPLOYEES WITH TEMPORARY CONTRACTS

Please complete this package if your injury at work resulted in medical attention, time off work or modified duties/hours.

NOTE: *Christian Horizons has an internal insurance plan that provides specific support for an employee who has been injured at work. Christian Horizons* ***does not and is not required to subscribe to WSIB insurance****. For a workplace injury please complete the forms attached and submit to AIG Insurance Company of Canada.*

Employees Responsibilities:

- Notify your Supervisor and seek immediate medical attention within 24 hours of the incident, if required (e.g. family doctor, urgent care or emergency dept.).
- Complete the enclosed Accident/Incident/Occupational Illness/Near Miss Report Form P-5:1 within 24 hours from the incident and submit the completed form to all parties listed on the form.
- Have your health care provider complete and sign the Attending Physician's Statement at your first visit.
- Complete and sign the employee portion (Claimant's Statement) of the Weekly Accident Indemnity form.
- Send the complete package to the Abilities Specialist so the Employer's Statement portion can be completed, and the entire package sent to AIG.
- Send all expense reimbursement claims to AIG directly.
- Familiarize yourself with the benefits available through AIG Insurance Company of Canada (AIG brochure attached)
- Actively participate in the Injury at Work process including the return to work process, follow the recommended treatment plan, work within the limitations/restrictions of a return to work plan, participate in the accident investigation.
- Review Christian Horizons' Policy for Injury at Work, including the Role of the Employee with the Disability.

Supervisor Responsibilities:

- Provide the employee with access to immediate medical attention (ambulance, taxi if necessary).
- Ensure the employee understands Christian Horizons' Injury at Work Policy E. 6.2.2, the required timelines to seek treatment, and takes this package to their Health Care Provider for the initial visit.
- Immediately offer the employee modified hours and/or duties if appropriate. Please consult with your Supervisor, the Abilities Specialist or the HRM (as needed).
- Inform the next level Supervisor of the injury at work and complete the P-5:2 Accident Investigation Report.
- Send both the P-5:1 Employee Accident/Occupational/Illness Report and the P-5:2 Accident Investigation Report to: accidentreports@christian-horizons.org and to your District office within 24 hours of completion.
- P-5:1 Employee Accident/Occupational/Illness Report must be completed within 24 hours of the incident and P-5:2 Accident Investigation Report must be completed immediately after the incident.
- Send a P-9:9b to HR Admin and Abilities Specialist if employee misses any shifts following the accident/incident.
- Send all medical documentation received to the Abilities Specialist.
- Submit P-9:9(b) to HR Admin and Abilities Specialist when the employee's status changes.
- Work with the employee, their Health Care Providers, Area Manager and the Abilities Specialist to facilitate a safe and timely return to work as soon as appropriate; create the Return to Work Plan in participation with employee.

AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

WEEKLY ACCIDENT INDEMNITY
Claimant's Statement

PLEASE PRINT **Policy #**

Please ensure that original claim documents and invoices are submitted

Surname: Given Name

Address:
(Street & No.) E-Mail:

Apt./Unit No.: Telephone No.: ( )

City/Town Province Postal Code:

Date of
Birth (M/D/Y): Height: Weight: Sex: Male☐ Female

1. Date of Accident (M/D/Y):_____

2. Full details of accident and injury sustained:_____

_____

3. Have you had a similar injury previously? Yes_____No_____

Provide dates and details:_____

4. Name and Address of Physician:_____

5. Where and when did your Physician first attend you?_____

6. Names and Addresses of any other physicians who may have treated you as the result of this accident.

_____

7. What other accident or health insurance do you have?

Company:_____Indemnity:_____

8. Are you receiving a disability pension, W.S.I.B. or unemployment benefits? Yes ( ) No ( )

If "yes", for what?_____Amount: $_____Date of First Payment:_____

9. (a) Are you/were you totally disabled? Yes ( ) No ( ) From _____ To _____

(b) Are you/were you house confined? Yes ( ) No ( ) From _____ To _____

(c) Are you/were you hospitalized? Yes ( ) No ( ) From _____ To _____

If "yes", name and address of Hospital_____

10. (a) When did you or will you resume work - PART TIME? Date:_____Time:_____AM/PM

(b) When did you or will you resume work - FULL TIME? Date:_____Time:_____AM/PM

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-coordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Dated_____Insured/Insured's Parent/Guardian Signature_____

AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

ATTENDING PHYSICIAN'S STATEMENT

The patient is financially responsible for the completion of the form

Physician's Name (Print)
Name:_____

Address: _____

_____

Phone # _____

Patient's Name (Print)
Name:_____

Address: _____

_____

Phone # _____

Diagnosis including complications (if fracture, specify bone and type of fracture) and Nature of Injury:

_____

_____

_____

DATE OF

First Attendance M D Y

Actual Loss

Is condition the result of an accident? Y ( ) N ( )

Please outline the treatment plan recommended and prescribed:_____

Date of next scheduled follow up appointment:_____

Is your patient totally disabled and unable to perform their occupational responsibilities? ☐ Yes ☐ No

Please provide the term of total disability: From:_____To:_____

Please provide the expected return to work date: _____

Was claimant hospitalized? ( ) No, and if ( ) Yes - Give hospital name, address and date admitted.

_____

Names and addresses of other physicians or surgeons, if any, who attended claimant

_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____ SIGNATURE: _____ M.D.

ADDRESS:_____

EMPLOYER'S STATEMENT

Name of Employee:_____Date of Employment:_____

Name of Employer:_____

Address of Employer: _____

Did the injury occur while claimant was performing the regular and assigned duties of their occupation? Yes ☐ No ☐

Did the injury occur while claimant was travelling directly to or from their regular place of employment? Yes ☐ No ☐

Description of Injury: _____

Employee was: ☐ Full-time ☐ Part-time ☐ Contract ☐ Seasonal ☐ Other _____

Employee was: ☐ Salary, weekly salary $_____ ☐ Hourly $_____/ Hr x # _____ Hrs/week ☐ Commissioned

Note: if employee works on shift schedule, then please attach a list of the dates of shifts missed and the hours scheduled
If insured's scheduled hours vary from week to week, then please provide an average of hours worked in the 4 weeks prior to the date of incident.

Occupation/Job Title:_____ Date Last Worked:_____Class No. (if applicable) _____

Will or is this employee receiving any source of income replacement during his/her term of disability (i.e. W.S.I.B, short/long term disability benefits). If yes; please advise source and amount being paid:_____

Date :_____Signature:_____

Telephone No.:_____Title:_____

Special Risk

For: Employees of Christian Horizons

Policy No.: SRG 9020558A

Why You Need Accident Insurance

A serious occupational accidental injury or death can have tremendous consequences. A serious occupational injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer, Christian Horizons, has provided for you, occupational Accident Insurance coverage while you are performing your duties at Christian Horizons, underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an occupational accident. Your accident coverage also provides you with 'living benefits' should an occupational accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

Occupational Activity Definition

means any activity undertaken by you while your coverage hereunder is in effect and undertaken in the course of your employment with Christian Horizons and while on assignment by or at the direction of Christian Horizons for the purpose of furthering the business of Christian Horizons, excluding getting to and from your regular place of employment and excluding any activity undertaken while you are on a leave of absence or vacation from work.

How It Works

You are automatically covered for a Principal Sum amount of $50,000.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

Occupational Coverage - Your coverage is in force while you are performing the duties of your occupation for your Employer.

Definitions

"Insured Employee" means you, if you are an active employee of the Policyholder who is under the age of 70 and a member of one of the following classes:

Class I: All active casual employees and employees of the Policyholder with contracts of less than 16 hours per week and who are under the age of 70.

Class II: All active part-time and full-time temporary employees of the Policyholder who are under the age of 70.

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 21 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 25 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

If you are an Insured Employee and you suffer loss of life, benefits will be paid to the person or persons who are on file with your Employer as having been most recently designated by you under your Employer's current basic group life insurance policy to receive the death benefit under such policy. In the absence of any such designation, the beneficiary shall be your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of losses

Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of entire sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one foot and the entire sight of one eye	The Principal Sum
Loss of one arm or one leg	Four-fifths of the Principal Sum
Loss of one hand or one foot	Three-quarters of the Principal Sum
Loss of the entire sight of one eye	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand	One-third of the Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of speech or hearing	Three-quarters of the Principal Sum
Loss of hearing in one ear	Two-thirds of the Principal Sum
Loss of four fingers of one hand	One-third of the Principal Sum
Loss of all toes of one foot	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands	The Principal Sum
Loss of use of one hand or one foot	Three-quarters of the Principal Sum
Loss of use of one arm or one leg	Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs)
Two times The Principal Sum up to a maximum of one million dollars

Paraplegia (total paralysis of both lower limbs)
Two times The Principal Sum up to a maximum of one million dollars

Hemiplegia (total paralysis of upper and lower limbs of one side of the body)
Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to "Quadriplegia", "Paraplegia", and "Hemiplegia" means the complete and irreversible paralysis of such limbs; "Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; "Arm" or "Leg" means the complete severance through or above the elbow or knee joint; "Thumb and Index Finger" means the complete severance through or above the first phalange; "Fingers" means the complete severance through or above the first phalange of all Four Fingers of One Hand; "Toes" means the complete severance of both phalanges of all the Toes of One Foot; "The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; "The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; "Hearing in One Ear" means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Hearing" means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Speech" means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. "Loss" when used herein may also include "Loss of Life".

Weekly Accident Indemnity Benefit

If you suffer Injury, within thirty days after the date of the accident causing Total Disability, the Company shall pay a Weekly Accident Indemnity Benefit during a period of continuous Total Disability subject to the following conditions:

Total Disability Weekly Accident Indemnity Benefit for Insured Employees:

Benefit Amount: 75% of your Regular Gross Weekly Income up to a maximum of $1,000 per week for a maximum of:

Class I: 26 weeks for any one period of continuous Total Disability with no waiting period.

Class II: 13 weeks for any one period of continuous Total Disability after a four day waiting period.

Waiting Period: from the date you have been determined by a Physician to be impaired from performing the regular duties of your occupation with your Employer is as per above.

Partial Return to Work or Partial Disability Weekly Accident Indemnity Benefit: Your weekly accident indemnity benefit reduced by 50% of your remuneration earned in the partial return to work program or if a return to work program is not available; 50% of your Benefit Amount as shown above up to 50% of the Maximum Number of Weeks Payable as shown above.

Accidental Para-Medical Expense Reimbursement Benefit

If as a result of Injury, and within 30 days from the date of the accident causing such Injury, you obtain medical treatment in Canada from a legally qualified Physician and as a consequence of such Injury incurs expenses for any of the following services when recommended by a legally qualified Physician, the Company shall reimburse you the reasonable and necessary expenses for the following para-medical services:

(a) private duty nursing by a licensed graduate nurse (R.N.), who does not ordinarily reside your home and who is not a member of your Immediate Family. This benefit is payable up to $50 per hour to a maximum of $5,000 for all Injuries resulting from any one accident;

(b) transportation, when such service is provided by a professional ambulance service to the nearest approved Hospital which is equipped to provide the required and recommended necessary treatment. This benefit is payable up to a maximum of $5,000 for all Injuries resulting from any one accident;

(c) Hospital charges for the difference between the public ward allowance under your provincial or territorial government health insurance plan and the semi-private accommodation charge for a semi-private Hospital room. This benefit is payable up to a maximum of $5,000 per for all Injuries resulting from any one accident;

(d) rental of a wheelchair, iron lung or other durable equipment, not to exceed the purchase price prevailing at the time rental became necessary;

(e) fees for services of a licensed physiotherapist. This benefit is payable up to a maximum of $300 for all Injuries resulting from any one accident;

(f) prescription drugs and medicines (except in the Province in Quebec);

(g) expenses for hearing aids, crutches, splints, casts, trusses and braces, but excluding replacement thereof; and

(h) fees for services of a licensed chiropractor. This benefit is payable up to a maximum reimbursement of $300 for all Injuries resulting for any one accident.

Reimbursement shall only be made provided that expenses are:

(a) incurred in Canada;
(b) incurred within 52 weeks of the date of the accident causing Injury;
(c) incurred only for therapeutic and not elective treatment; and
(d) which are supported by original receipts submitted to the Company as proof of claim.

This benefit is in excess of any similar benefit provided under any other insurance, policy or plan, including but not limited to a policy of automobile insurance and any federal or provincial hospital, medical or drug plan.

The maximum amount payable for this benefit is $10,000 for all Injuries resulting from any one accident.

Accidental Dental Expense Reimbursement

If you suffer Injury to whole and sound teeth, and within 30 days from the date of the accident causing such Injury obtain treatment in Canada for such Injury from a legally qualified dentist or dental surgeon and incur related dental expenses, the Company shall reimburse you the amount for such dental expenses up to the amount allowed for such service in the General Practitioner Schedule of Fees and Treatment Services of the Provincial Dental Association in the province or territory in which you receive such treatment.

Reimbursement shall only be made provided that expenses are:

(a) incurred in Canada;
(b) incurred within 52 weeks of the date of the accident causing Injury;
(c) incurred only for therapeutic and not elective or aesthetic treatment; and
(d) which are supported by original standard dental claim form submitted to the Company as proof of claim.

This benefit is in excess of any similar benefit provided under any other insurance, policy or plan, including but not limited to a policy of automobile insurance and any federal or provincial hospital, medical or drug plan.

The maximum amount payable for this benefit is $500 dollars for all Injuries resulting from any one accident.

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit (for employees only)

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometers from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometers from home.

Identification Benefit

Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometers from home and a law enforcement agency requests such identification.

Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit

Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense

Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit

Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by the Insured Employee while sane;
(b) self inflicted Injury or any attempt thereat by the Insured Employee while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) sustained while the Insured Employee is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Employee is:
    i. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    ii. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    iii. riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(j) injury or Loss sustained while the Insured Employee is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Employee is on full-time active duty shall, upon application to the Company by the Policy holder, be refunded);
(K) injury or Loss sustained while the Insured Employee is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;
(l) injury or Loss sustained while the Insured Employee is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;
(m) the commission or attempted commission by an Insured Em ployee or Injury incurred while an Insured Employee is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;
(n) an act, attempted act or omission taken or made by the Insured Employee, or an act, attempted act or omission taken or made with the Insured Employee's consent, for the purposes of inter rupting the blood flow to the Insured Employee's brain or to cause asphyxiation to the Insured Employee whether with intent to cause harm or not;
(0) natural causes; and
(p) an accident occurring while the Insured Employee is not enga ged in an Occupational Activity.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the Policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date

Your coverage begins on the date you satisfy the definition of "Insured Employee".

Termination Date

Coverage ends on the earliest of:
(1) the date the policy is terminated; (2) the premium due date if premiums are not paid when due; (3) the date you no longer satisfy the definition of an Insured Employee; or (4) the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

ACCIDENT/INCIDENT/OCCUPATIONAL ILLNESS/ NEAR MISS REPORT

This form must be submitted within 24 hours of the incident.

This form is to be completed by the employee immediately after an incident *(please print using black ink and print clearly if handwritten)*

Last Name: First Name:

Employee #: Position:

Program Name and #:

Date Of Accident: Time (2400):

Date Reported to Supervisor: Time (2400):

Was a person supported involved? ☐ Yes ☐ No

Location of Incident: Did the incident/injury occur during the application of restraints? ☐ Yes ☐ No

Witnesses (people present at time of accident):

State the incident including sequence of events leading up to the Incident:

TYPE OF INCIDENT

- ☐ Struck By or Contact With
- ☐ Caught In/On or Between
- ☐ Fall/Slip
- ☐ Over Exertion/Strain
- ☐ Exposure/Environmental
- ☐ Occupational Illness
- ☐ Sharps/Needle Stick
- ☐ Fire/Explosion
- ☐ Violence/Assault
- ☐ Motor Vehicle Accident
- ☐ Near Miss*
- ☐ Other: _____

*If you are reporting a near miss, was it due to: ☐ Unsafe Act ☐ Unsafe Condition ☐ Unsafe Equipment

Indicate type of injury, part of body involved and specify right or left side (below):

INJURY TO: (L= Left / R= Right)	**L**	**R**
☐ Face or Head	☐	☐
☐ Eye/Ear	☐	☐
☐ Upper Back	☐	☐
☐ Lower Back	☐	☐
☐ Neck / Shoulder	☐	☐
☐ Arm / Wrist	☐	☐
☐ Hand / Fingers	☐	☐
☐ Leg	☐	☐
☐ Toe / Foot	☐	☐
☐ Abdomen	☐	☐
☐ Chest	☐	☐
☐ Other: _____	☐	☐

TYPE OF INJURY:

- ☐ Laceration
- ☐ Strain / Sprain
- ☐ Bruise(s)
- ☐ Fracture
- ☐ Puncture
- ☐ Abrasion
- ☐ Amputation
- ☐ Burns
- ☐ Foreign Body
- ☐ Skin
- ☐ Exposure
- ☐ Other: _____

TREATMENT *(Must choose one)*:

- ☐ On-site First Aid Only
- ☐ Hospital Emergency Dept.
- ☐ Doctor's or Other Professional Care
- ☐ None

CLAIM TYPE *(Must choose one)*:

- ☐ Lost Time From Work (missed next shift)**
- ☐ No Lost Time From Work (did not miss next shift)
- ☐ Near Miss*
- ☐ Critical Injury - **Reported to Ministry of Labour**

Have you had a similar injury or disability? ☐ Yes ☐ No If yes, explain:

**If you lost time, when did you leave work? Date: Time (2400):

(Injury at Work – IAW package must be completed for lost time claims)

Please provide recommendations to prevent recurrence:

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

DISTRIBUTION: Forward to the appropriate locations within 24 hours

1. Email: accidentreports@christian-horizons.org
2. Immediate Supervisor
3. District Office/Waterloo Office Supervisor
4. Health and Safety Representative/Joint Health & Safety Committee