COMBINED INSURANCE

Canadian Head Office: Claims Department
P.O. Box 3720 MIP • Markham, ON L3R 0X5 • Fax: 905-754-4362

COMBINED ASSURANCES

Income Guard - Claim Form

This form to be fully completed and returned within 90 days of the loss

Claimant's Statement

PLEASE PRINT

Last Name of Insured	Given Name		Telephone Number	Policy Number(s)	Form Number(s)
				a)	a)
Mailing Address	Street	Apt. #	Weight	b)	b)
City	Province	Postal Code	Height	c)	c)
Birthdate (MM, DD YYYY)	Age	Sex ☐ M ☐ F	Spouse's Name		

COMPLETE FOR ACCIDENT	Date of accident (MM/DD/YYYY)	Time	☐ AM ☐ PM	Location	Injuries sustained
	Please describe in detail how accident occurred (Attach diagram or extra sheet if necessary)				
COMPLETE FOR SICKNESS	Date of first symptoms (MM/DD/YYYY)	Have you ever had same or similar condition? If "Yes", give date (MM/DD/YYYY) ☐ Yes Date _____ ☐ No			
	Nature of sickness				

COMPLETE IF YOU ARE EMPLOYED	Occupation		
	Type of work (please attach Job description, if available)		
	Is this a Worker's Compensation claim? ☐ Yes If yes, attach accident report ☐ No		
EMPLOYER'S STATEMENT	Name, address and phone number of employer		
	First day of absence from work (MM/DD/YYYY)	Date of return to work (MM/DD/YYYY)	
	First day of gradual return to work (MM/DD/YYYY)		
	Employer's signature	Title	Date signed (MM/DD/YYYY)
COMPLETE IF YOU ARE SELF EMPLOYED	Occupation/Name of your business		
	Job description		
COMPLETE IF YOU ARE UNEMPLOYED OR RETIRED	Describe your usual daily activities prior to the onset of your accident or sickness		
EMPLOYMENT STATEMENT	1) What was your monthly income prior disability? _____/month ☐ Gross ☐ Net	**Note:** Please provide us with your last two pay stubs	
	2) Has a return to work plan been established? ☐ Yes (If "Yes", go to question 2b) ☐ No (If no, go to question 2a)		
	2a) If "No", when will you be assessed by your doctor a possible return to work? (MM/DD/YYYY)		
	2b) If "Yes", what is the expected return to work date? (MM/DD/YYYY)		
	2c) If a return to work is part-time or gradual, please provide us with the gradual schedule		

OTHER INSURANCE INFORMATION Please **complete this section if the *Income Benefit Rider* was selected** on the Income Guard product	**Benefits**	**Yes**	**No**	**Policy/Claim Number**	**Monthly Benefit Amount (gross)**	**Benefit Start Date** (MM/DD/YYYY)	**Benefit Period** (EX.: 1, 2 or 5 YEARS)	**Submitted, Approved or Declined ***	**Examiner's Name and Phone Number**
	WCB/WSIB/CSST	☐	☐						
	Group Insurance Name:	☐	☐						
	Canada Pension Plan (Disability)	☐	☐						
	Regie des rentes du Québec (Disability)	☐	☐						
	Old Age Security	☐	☐						
	Employment Insurance Type :	☐	☐						
	Creditor Insurance Name : Type:	☐	☐						
	Other type of Insurance (Loan, Mortgage, etc) Name :	☐	☐						
	***If your claim has been Approved or Denied, please submit a copy of the letter or benefit payment indicating the start date and the end date of the paid benefits.**								

INSTRUCTIONS REGARDING THE LOAN BENEFIT RIDER Please **consider this section if the *Loan Benefit Rider* was selected on** the Income Guard product	If you are filing a claim under the Loan Benefit Rider, please provide a copy of your eligible loan statements from 120 days prior to the start date of the disability. **Eligible Loan means:** Any loan with a Financial Institution covered by a contract that clearly sets out the loan's initial date, initial amount and maturity date, as well as the monthly payment payable until the loan's maturity date. Eligible Loan includes the following types of loans: any fixed-term loan for which you are personally and legally responsible as a borrower or co-borrower with a recognized financial institution including, but not limited, to any personal or business loan (e.g., leveraged investment loan, car loan, boat loan, motorcycle loan, recreational vehicle (RV) loan, student loan, renovation loan), line of credit, lease, mortgage loan and home equity line of credit. *Credit card debt is not considered an eligible loan. Loans between individuals are not considered eligible loans.*

COMPLETE FOR ACCIDENT OR SICKNESS			
	Dates during which you were unable to do all the duties pertaining to your usual occupation or perform your usual daily activities. (MM/DD/YYYY) (MM/DD/YYYY)		
	First day of total disability:	**Last day of total disability:**	
	Dates during which you were able to perform part of the duties pertaining to your usual occupation or perform part of your usual daily activities. (MM/DD/YYYY) (MM/DD/YYYY)		
	First day of partial disability:	**Last day of partial disability:**	
	Are you still totally disabled? ☐ **Yes** ☐ **No**		
	Your doctor's name, address and phone number	**Hospital name, address and phone number**	**Date of confinement** (MM/DD/YYYY) **- Admission date:** **- Discharge date:**

Protecting your Personal Information At Combined Insurance, we recognize and respect the importance of privacy. Personal information that we collect, store, and disclose is used for the purposes of investigating, assessing and administering your claim(s). For a copy of our Privacy brochure, or if you have any questions about our personal information policies and practices (including with respect to service providers), write to our Chief Privacy Officer or refer to www.combined.ca.

Authorization and Declaration I have read, understand and agree with the contents of the section entitled "Protecting your Personal Information" on this form. I authorize Combined Insurance, any healthcare provider, any insurance or reinsurance company, administrators of government benefits or other benefits programs, or any person having knowledge of me or my health, other organizations or service providers working with Combined Insurance, located within or outside Canada, to exchange personal information when relevant for the purposes of investigating, assessing and administering my claim(s). This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me in writing. I declare that the information provided is true, accurate and complete to the best of my knowledge.

Signature of Insured	**Date** (MM/DD/YYYY)

IMPORTANT: Review your claim form. Is it complete? A form not fully completed may delay settlement of your claim. Also retain a copy of both sides of your completed claim form.

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ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for securing this form and for charges incurred for its completion.

Name of patient: _____ Date of birth (MM/DD/YYYY) _____

1. Diagnosis of present condition (specific medical diagnosis)

   a) Primary Diagnosis _____

   b) Additional conditions or complications _____

   c) Objective findings (including results of x-rays, laboratory data or any other special tests). Attach all test results/specialist reports. _____

   _____

2. If condition is due to pregnancy, what it the expected delivery date? (MM/DD/YYYY) _____

3. If this condition is due to:

   a) **Sickness –** Date symptoms first appeared (MM/DD/YYYY) _____

   Has patient ever had same or similar condition? ☐ Yes If "Yes", state when and describe under section 11.
   ☐ No

   b) **Accident (Injury) –** Date accident happened (MM/DD/YYYY) _____

   c) How did condition/injury originate? _____

   d) Is this disability due to: ☐ Occupational or ☐ Non-occupational

4. a) If patient was referred to you, give complete name of referring physician _____

   b) If you have referred patient to a specialist, give complete name(s) of physician(s) _____

   _____

5. a) Date patient first consulted for present condition (MM/DD/YYYY) _____

   b) Date of last visit (MM/DD/YYYY) _____

   (c) Were you actively supervising patient's care during full period?

   ☐ Yes Frequency: ☐ weekly ☐ monthly ☐ Other (Specify) _____

   ☐ No If "No", please comment under section 11.

6. Please provide all the consultation dates this patient has been under your care in regards to this disability

   _____ _____ _____ _____ _____

   _____ _____ _____ _____ _____

   _____ _____ _____ _____ _____

   _____ _____ _____ _____ _____

7. Nature of Treatment (e.g. date and type of surgery, including medication) _____

   _____

8. Has the patient been compliant with the medical treatment plan?

   ☐ Yes ☐ No (If "No", please specify) _____

9. a) Emergency Room – Admission Date (MM/DD/YYYY) _____ Time (HH/MM) _____

   b) Emergency Room – Discharge Date (MM/DD/YYYY) _____ Time (HH/MM) _____

   c) Inpatient Hospital Confinement – Admission Date (MM/DD/YYYY) _____ Discharge Date (MM/DD/YYYY) _____

10. To the best of my knowledge,

a) The patient has been totally disabled (unable to work or perform daily activities) from _____ to _____ inclusive.

b) The patient has been partially disabled (able to perform some duties at work or some daily activities) from _____ to _____ inclusive.

c) What are the restrictions and limitations preventing patient from returning to work or doing daily activities? _____

_____

d) If still unable to work or perform daily activities, give approximate date when patient should be able to return to work or perform daily activities.

(MM/DD/YYYY) _____

	Activities	The patient is able to perform	The patient is able to perform with limitations	The patient is unable to perform
IF THE PATIENT WAS **UNEMPLOYED PRIOR TO THE DISABILITY,** please confirm if the patient is able to do the following. (Check all that applies)	Housework	☐	☐	☐
	Preparing meals	☐	☐	☐
	Participating in hobbies: (Specify):	☐	☐	☐
	Shopping	☐	☐	☐
	Managing finances	☐	☐	☐
	Taking medication as prescribed	☐	☐	☐

11. Please provide comments and further details you feel would be helpful: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of attending physician (please print) _____	**Specialty** _____
Address _____	**Telephone** _____
Signature	**Date** (MM/DD/YYYY)

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