COMBINED INSURANCE COMPANY OF AMERICA
COMPAGNIE D'ASSURANCE COMBINED D'AMÉRIQUE

CANADIAN HEAD OFFICE P.O. BOX 3720 MIP, MARKHAM, ON L3R 0X5
FAX: 905-754-4362

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

CLAIMANT'S STATEMENT

PLEASE PRINT

NAME OF INSURED LAST NAME / GIVEN NAME	TELEPHONE	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		

If insured is a minor, please provide the name of a legal guardian/parent who resides with child. Provide any relevant information (custody order or legal guardianship), if applicable.

Address of legal guardian if different from minor

Section				
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			
	Is this a Worker's Compensation claim? Yes ☐ If yes, attach accident report No ☐			
EMPLOYER'S STATEMENT	Name and address 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			
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. First day of total disability: (MM/DD/YYYY) Last day of total disability: (MM/DD/YYYY)			
	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. First day of partial disability: (MM/DD/YYYY) Last day of partial disability: (MM/DD/YYYY)			
	Are you still totally disabled? Yes ☐ No ☐			
	Your doctor's name and address	Hospital name and address	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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COMBINED INSURANCE

ATTENDING PHYSICIAN'S STATEMENT

COMBINED ASSURANCES

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 is the expected delivery date? ____________________

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 section10.
   No ☐
   (b) **Accident (Injury)** – Date accident happened (MM/DD/YYYY) ____________________
   (c) How did condition/injury originate? ____________________

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 section10.

6. (a) Emergency Room – Admission Date and Time (MM/DD/YYYY) ____________ Discharge Date and Time (MM/DD/YYYY) ____________
   (b) Inpatient Hospital Confinement – Admission Date (MM/DD/YYYY) ____________ Discharge Date (MM/DD/YYYY) ____________

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

8. 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? ____________________
   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.
   ____

9. If patient is a student, what are the restrictions and limitations affecting his/her daily activities? ____________________

10. Please provide any other information that would be helpful in the assessment of your patient's claim ____________________

Name of attending physician (please print) ____________________ Specialty ____________

Address ____________________ Telephone ____________

Signature ____________________ Date ____________