COMBINED INSURANCE

Canadian Head Office: Claims Department
P.O. Box 3720 MIP • Markham, ON L3R 0X5

COMBINED ASSURANCES

PLEASE COMPLETE AND RETURN ON ______________________________

Claim #

CLAIMANT'S SUPPLEMENTARY STATEMENT — *PLEASE PRINT*

Name	Telephone Number
Address	
Please describe any complications of injury or illness since last report	
List medical treatments received since last report	

Doctor's name and address	Treatment dates (MM/DD/YYYY)	
Hospital where confined since last report	Date of hospitalization	
	From	To

		MM/DD/YYYY
Have you been totally disabled to this date?	Yes ☐ No ☐	
When did you resume part of your duties?		
When did you resume all of your duties?		
When do you expect to resume part of your duties?		
When do you expect to resume all of your duties?		

MY CLAIM IS ON THE FOLLOWING BASIS

		MM/DD/YYYY
Dates during which I was unable to perform **all** the duties pertaining to my usual occupation	First day of total disability	
	Last day of total disability	
Dates during which I was able to perform **part** of the duties pertaining to my usual occupation	First day of partial disability	
	Last day of partial disability	

EMPLOYER'S STATEMENT

	MM/DD/YYYY
First day of absence from work	
Return to work	

Partially disabled	From:	To:
Name of Employer		
Signature	Title	Signed on MM/DD/YYYY

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE any hospital or physician who has attended me to disclose, when requested to do so by the Combined Insurance Company of America, any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

______________________________ ______________________________
SIGNATURE OF CLAIMANT DATE (MM/DD/YYYY)

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

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT — *PLEASE PRINT*

Please return completed form to your patient. The patient is responsible for securing this form and for charges made for its completion.

PATIENT NAME

1. DIAGNOSIS OF PRESENT CONDITION (SPECIFIC MEDICAL DIAGNOSIS)	A) PRIMARY B) SECONDARY (IF APPLICABLE)
2. INDICATE COMPLICATIONS OR NEW INDEPENDENT CONDITIONS, SUCH AS SURGERY, WHICH MAY PROLONG THE DISABILITY.	DESCRIBE
3. DATE OF LATEST ATTENDANCE	DATE (MM/DD/YYYY)
4. HAVE YOU BEEN ACTIVELY SUPERVISING PATIENT'S CARE?	YES ☐ IF YES, STATE FREQUENCY OF VISITS (ON RIGHT) WEEKLY ☐ MONTHLY ☐ NO ☐ IF NO, COMMENT IN REMARKS (#9) OTHER (SPECIFY)
5. IS PATIENT FOLLOWING RECOMMENDED TREATMENT PROGRAM?	YES ☐ IF YES, STATE DATE OF LATEST TREATMENT DATE (MM/DD/YYYY) ____ NO ☐ IF NO, COMMENT IN REMARKS (#9)
6. TO THE BEST OF YOUR KNOWLEDGE, IS THE PATIENT **TOTALLY** DISABLED (UNABLE TO WORK/PERFORM USUAL ACTIVITIES)?	YES ☐ IF YES, GIVE APPROXIMATE DATE WHEN PATIENT SHOULD BE ABLE TO RETURN TO WORK. DATE (MM/DD/YYYY) NO ☐ IF NO, ON WHAT DATE COULD THE PATIENT HAVE RETURNED TO WORK? DATE (MM/DD/YYYY) INDEFINITE ☐ IF INDEFINITE, GIVE THE ESTIMATED NUMBER OF ADDITIONAL WEEKS BEFORE SUCH RETURN ____
7. HOW LONG WAS OR WILL PATIENT BE **PARTIALLY** DISABLED (ABLE TO WORK PART-TIME AT OWN OCCUPATION)?	FROM (MM/DD/YYYY) TO (MM/DD/YYYY)
8. IS PATIENT A SUITABLE CANDIDATE FOR A REHABILITATION PROGRAM?	YES ☐ NO ☐
9. REMARKS. PLEASE PROVIDE COMMENTS AND FURTHER DETAILS WHICH YOU FEEL WOULD BE HELPFUL.	

PHYSICIAN'S NAME	TELEPHONE NUMBER
ADDRESS	POSTAL CODE
PHYSICIAN'S SIGNATURE	DATE (MM/DD/YYYY)

COMBINED INSURANCE COMPANY OF AMERICA
COMPAGNIE D'ASSURANCE COMBINED D'AMÉRIQUE
Canadian Head Office: Claims Department
P.O. Box 3720 MIP • Markham, ON L3R 0X5
Telephone: 1 888 234-4466 • www.combined.ca

CONSENT TO ELECTRONIC TRANSACTIONS, PAYMENTS AND SIGNATURE

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America ("Combined"), of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at https://my.combinedinsurance.com or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department, Monday through Friday between 8:00 am and 7:00 pm EST, or go to www.combinedinsurance.com/ca-en/contact-us to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a chequing account or transfer into a PayPal account. Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a cheque mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

______________________________ Print Name

______________________________ Signature

______________________________ E-mail Address

______________________________ Date