COMBINED INSURANCE

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

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		Spouse's Name	Telephone Number
Mailing Address Street Apt. #			Preferred Method of Contact ☐ MAIL ☐ EMAIL	Policy Number(s) a)
City	Province	Postal Code	Email Address The email address provided will be used to communicate with you regarding your Combined Insurance claims only, and not for marketing and/or promotional reasons of any kind.	b)
Birthdate (MM, DD YYYY)	Age	Sex ☐ M ☐ F		c)

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	Job description available Yes ☐ If yes, please attach a copy No ☐	
	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, name and phone number	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		

	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
OTHER INSURANCE INFORMATION Please **complete this section if the *Income Benefit Rider* was selected** on the Income Guard product	**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. I understand that it is an offence under the Insurance Act to knowingly make any fraudulent, false or misleading statements or representations to an insurer under a contract of insurance. I understand that if Combined Insurance finds that I have provided fraudulent information or made any false or misleading statement, Combined Insurance may, in its discretion, deny the claim and/or rescind the policy.

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) _____

   d) Name of Hospital Where Treated _____

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)

Combined Insurance Company of America / Compagnie d'assurance Combined d'Amérique
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A Chubb Company / Une compagnie de Chubb

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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