Instructions for filing Accident and Sickness claims

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A Chubb Benefits Company

To ensure your claim is processed efficiently, please follow the steps outlined below. Complete all relevant sections of the form and attach any medical documents you have. Did you know you can file a claim online for faster service? Visit our website at **www.combined.ca.** For any questions, please contact us at **1-888-234-4466**.

Claimant's statement (to be completed by the claimant and employer)

- **Personal information:** Provide your full name and address. All payments and correspondence will be sent to this address unless directed otherwise
- **Policy numbers:** List all policy numbers associated with this claim (including family policies)
- **Medical details:**
  - ***For sickness:*** Describe your symptoms and date of diagnosis
  - ***For injury:*** Provide details of the accident that caused the injury and date of accident
- **Supporting documents:** Include reports to support your loss, such as outpatient surgery records, X-ray reports, police report and motor vehicle accident report. **If claiming for cancer, the pathology report is required**
- **Hospital details:**
  - Have the hospital's Health Records department complete the "Record of Hospital Care" form with admittance and discharge dates, hospital unit, diagnosis and hospital stamp
  - Obtain confirmation of admission from each hospital if you were admitted to multiple facilities
- **Ambulance:** Please provide the invoice. (**Note:** if you are only claiming this benefit, the Attending Physician's Statement or hospital records will also be required)
- **Disability information:** Specify the exact dates of partial and/or total disability (refer to your policy or policies for the definitions)
  - ***Unemployed/retired:*** Describe your daily activities prior to your disability
- **Employment confirmation:**
  - ***Employees:*** Have your employer confirm your absence due to disability (P5)
  - ***Self-employed:*** State the nature of your occupation and daily duties
- If you are claiming under an accident or sickness disability policy within 2 years of the policy effective date/reinstatement date, please provide the following documentation:
  - ***Self-employed:*** Notice of Assessment (NOA) for the most recent fiscal year
  - ***Employed:*** The two most recent pay stubs prior to the start of the disability period

Authorization: Sign and date the authorizations (pages 2 and 4) to allow us to obtain additional information if needed.

(**Note:** If your loss occurred within 2 years of the policy effective date/reinstatement date, we may require additional medical information which will delay the processing of your claim).

If you have an Income Guard policy, complete section 5.

Attending physician's statement (to be completed by your treating physician)

Diagnosis and treatment: Include the diagnosis, date of diagnosis, origin/cause of condition, and treatment dates.

- ***Outpatient:*** Provide the date of service and treatment type
- ***Inpatient***: Provide hospital confirmation with admittance and discharge dates

Clearly indicate the disability dates. Clearly indicate the restrictions and limitations. Provide the full address and phone number of the treating physician, and the family physician.

You should keep a copy of both sides of the claim form, including the date sent, for your records.

Combined Insurance Company of America, Claims Department, P.O.Box 3720 MIP, Markham, ON L3R 0X5

Fax: 905-754-4362
Email: canadian_claims_department@chubb.com
Online portal: my.combinedinsurance.com/en-CA/login

If you would like to give your agent authorization to obtain information on your claim and/or policies, please complete the "Authorization to disclose information to my insurance agent" form found on our website www.combined.ca.

Claimant's statement

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Complete **all 4 sections** to avoid delay in the processing of your claim. This form must be **returned within 90 days** of the loss.

1 – CLAIMANT'S INFORMATION

Last name: _____ First name: _____ Primary Insured/Owner ☐ Dependent ☐

Mailing address: _____ Policy number(s): _____

Province: _____ Postal code: _____ Date of birth: _____

Primary phone: _____ Alternative phone: _____

Email: _____ Preferred method of contact: Phone ☐ Mail ☐ Email ☐

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.

If insured is a minor, please provide the name and the address of the policy owner:

2 – MEDICAL AND EMPLOYMENT DETAILS

Diagnosis: _____ Date of first symptoms/injury (MM/DD/YYYY): _____

If it is due to injury, describe how it occurred:

Date that you first sought medical care for this condition (MM/DD/YYYY): _____

Name of doctor consulted: _____ Name of family doctor: _____

At the time of your loss were you: Employed ☐ Self-employed ☐ Retired/unemployed ☐ Student/child ☐

If employed/self-employed – what is your job title/nature of occupation and your regular daily duties?:

3 – DISABILITY

Were you disabled at any time following your condition? No ☐ Yes ☐ *If yes, complete the following questions:*

If employed, have your employer complete the "Employer's Certificate" form located below.

Total disability: Dates during which you were **unable to perform any duties** pertaining to your usual occupation (usual activities of daily living, if not employed)

First day of total disability (MM/DD/YYYY): _____ Last day of total disability (MM/DD/YYYY): _____

Expected date of return to work/usual activities of daily living (MM/DD/YYYY): _____

Partial disability: Dates during which you were **able to perform some duties** pertaining to your usual occupation (usual activities of daily living, if not employed)

First day of partial disability (MM/DD/YYYY): _____ Last day of partial disability (MM/DD/YYYY): _____

4 – CONSENT AND AUTHORIZATION

I consent and authorize Combined Canada to access, collect, retain, disclose, and exchange personal information. I understand that this consent will remain in place until such time as I revoke it. This consent and associated personal information will be managed according to the Combined Canada Privacy Policy published on: **https://www.combinedinsurance.com/ca-en/**

I understand that the personal information will be used to investigate, assess, and administer any application(s) or claim(s) I make. I affirm that all information I provide is true and I acknowledge that insurance fraud is illegal. In the event of a false or misleading statement in the making of this claim payment of benefits can be denied and past claims payments recovered without refund of any premiums paid. I agree to refund the Insurer the amount of any payments made in the event that such amounts should not have been paid in respect of this claim.

Personal information may be exchanged with any insurance company, healthcare provider, benefits administrator, MIB (Medical Information Bureau), provincial health care plan or other parties with knowledge of me or my health, located within or outside Canada, when relevant to investigating, assessing, and administering my application(s) and my claim(s). This personal information may be shared electronically, by phone, or in paper format and all exchanges of information will adhere to applicable privacy laws.

I understand I can request access to or correction of my personal information. For more details on my privacy rights, I can refer to the Privacy Policy linked above.

☐ Check this box if you are providing consent on behalf of another person. (Additional documentation required).

Name of claimant (print): _____ Signature of claimant: _____ Date (MM/DD/YYYY): _____

5 – IF YOU HAVE AN INCOME GUARD POLICY: Please complete this section

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)	☐	☐						
Régie des rentes du Québec (Disability)	☐	☐						
Old Age Security	☐	☐						
Employment insurance type:	☐	☐						
Creditor insurance Name: Type:	☐	☐						
Other type of insurance (loan, mortgage, etc.) Name:	☐	☐						

Note: 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.

Please provide a copy of the last 2 pay stubs before the period of disability and a Notice of Assessment (NOA) for the last fiscal year.

Attending physician's statement

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

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1 – PATIENT INFORMATION

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

2 – DIAGNOSIS

a. What is the primary diagnosis/condition: _____

Attach objective findings *(including results of x-rays, surgery report or any other tests).*

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

c. Based on your findings, is this due to: sickness, accident, gradual onset aggravation, or an existing condition: _____

d. Date the condition began including date of diagnosis/accident, if different (MM/DD/YYYY): _____

e. If due to injury, describe how it occurred: _____

f. Has patient ever had same or similar condition?: No ☐ Yes ☐ Provide details: _____

g. Secondary contributing conditions?: _____

3 – PHYSICIANS AND FOLLOW UP

a. Name of family physician: _____

b. Name of referring physician (if different): _____

c. Date patient first consulted for present condition (MM/DD/YYYY): _____

d. Were you actively supervising your patient's care?: No ☐ Yes ☐ If no, provide name of treating physician: _____

e. Date of next follow-up (MM/DD/YYYY): _____

4 – HOSPITALIZATION AND TREATMENT

a. Name of hospital where treated: _____

Emergency room
Arrival date and time (MM/DD/YYYY): _____ Departure date and time (MM/DD/YYYY): _____

Inpatient hospital confinement
Admission date (MM/DD/YYYY): _____ Discharge date (MM/DD/YYYY): _____

Outpatient surgery Date (MM/DD/YYYY): _____

b. Treatment (describe the treatment including type of surgery, prescribed medication, physical therapy, medical appliance/equipment):

5 – DISABILITY

What is your patient's occupation: _____ Retired/unemployed/student/child

a. List the restrictions and limitations and the duration of these:

b. **Total disability:** The patient has been **unable to perform <u>any</u>** occupational duties or (usual activities of daily living)

From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____ inclusive.

c. **Partial disability:** The patient has been **able to perform <u>some</u>** occupational duties or (usual activities of daily living)

From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____ inclusive.

d. Expected date of return to work/usual activities of daily living (MM/DD/YYYY): _____

e. If still unable to work or perform usual activities of daily living, what is the prognosis including treatment plan?:

6 – DOCTOR SIGNATURE AND INFORMATION

Name of attending physician (please print): _____ Speciality: _____

Address: _____ Fax: _____ Telephone: _____

Signature: _____ **License:** _____ **Date (MM/DD/YYYY):** _____

Employer's certificate

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1 – WORK ABSENCE INFORMATION

I hereby certify that (First, Middle, Last name): _____

Was absent from work from (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____ inclusive.

Resume **partial or modified** duties on (MM/DD/YYYY): _____

Resumed or expected to resume **full** duties on (MM/DD/YYYY): _____

2 – OCCUPATION INFORMATION

Job title, occupation and daily duties are as follows (please include job description if available):

Was an accident report filed for Worker's Compensation benefits? Yes ☐ No ☐

Is this person receiving group disability benefits? Yes ☐ No ☐

If the loss of time is due to an accident at work, please give the date and a detailed description of the accident:

3 – EMPLOYER'S IDENTIFICATION

Company name: _____

Company address: _____

Authorized person's name and job title: _____

Authorized person's contact information: _____

Authorized person's signature: _____ Date (MM/DD/YYYY): _____

Consent to electronic transactions, payments and signature

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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 emails 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 chequeing 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.

Consent to electronic transactions, payments and signature

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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.

Primary Insured / Owner (print name)

Primary Insured / Owner (signature)

Email address

Date (MM/DD/YYYY)

THIS FORM MUST BE COMPLETED BY THE PRIMARY INSURED UNDER THE POLICY FOR WHICH YOUR CLAIM WAS SUBMITTED. IF THE PRIMARY INSURED IS A MINOR, THE FORM MUST BE COMPLETED BY THE POLICY OWNER. IF THE FORM IS INCOMPLETE OR COMPLETED BY THE WRONG PERSON, PAYMENT WILL DEFAULT TO A CHEQUE.

Things to know about electronic payments:

1. **Hyperwallet registration:** If your claim is approved, you'll receive a confirmation email. You must register with Hyperwallet within three (3) calendar days of receiving this email. If your phone number is not the same as the one on file with Combined Insurance, you won't be able to receive the code needed to activate your account. It's important to keep your contact information up to date and notify us of any changes before requesting electronic payments.
2. **Check your email regularly:** After submitting a claim, regularly check your email, including folders like junk or spam, for important updates or instructions regarding your payment.
3. **Update banking and contact information:** If you have previously received an electronic payment, ensure you provide Hyperwallet with your updated banking and contact information to avoid delays.
4. **Failed or expired transactions:** The payment will default to a cheque after three (3) calendar days of receiving this email.