INSTRUCTIONS FOR FILING ACCIDENT AND HEALTH CLAIMS

To avoid delays, please answer all applicable questions on the claim form and attach any medical information that you may have on hand.

CLAIMANT'S STATEMENT
TO BE COMPLETED BY THE CLAIMANT AND EMPLOYER

Please be sure to give complete name and address. Your payment and/or any correspondence will be mailed to the address unless we are directed to do so otherwise.

Write down all policy numbers.

If filing for loss due to sickness, fill in the first section of the form relating to your symptoms and diagnosis. For loss due to an injury, give us the requested information regarding the accident that caused the injury.

Please provide any reports to substantiate your diagnosis i.e.: outpatient surgery, X-ray report, pathology etc.

If hospitalized, please have the hospitalization form fully completed and signed by the Health Records Department. If you were hospitalized in more than one hospital, please provide a confirmation from each hospital. The confirmation must contain:

- The admittance and discharge dates
- The unit or section in which you were hospitalized
- The hospital seal of the records department

If you are claiming for disability, please indicate the exact dates of partial and/or total disability.

If gainfully employed outside the home, the employer must confirm your absence for disability. If the Insured is a student, the school principal should complete this section.

If you are self-employed give us the nature of your occupation.

Please be sure to sign and date the authorization section located near the bottom of the form to enable us to obtain additional information, if necessary. This will save processing time in the event that additional information is needed.

ATTENDING PHYSICIAN'S STATEMENT
TO BE COMPLETED BY YOUR TREATING PHYSICIAN

For a sickness or accident claim, the primary physician must complete the form, providing the diagnosis, how the condition originated, and the dates of treatment. If treated as an outpatient we need the service date. If treated as inpatient, you must provide confirmation of hospitalization from the Health Records Department of the hospital(s) attended.

Disability dates, both total and partial, must be indicated by the doctor. Please provide the doctor's complete address and phone number.

For your records, we suggest that you make a copy of both sides of the claim form and of any bill(s) you submit. Note the date mailed. Mail the completed form and any enclosures to:

COMBINED INSURANCE COMPANY OF AMERICA
CLAIMS DEPARTMENT
P.O.BOX 3720 MIP
MARKHAM, ON L3R 0X5
Toll free number: 1-888-234-4466
Fax: 905-754-4362