

INSTRUCTIONS FOR FILING A CANCER CLAIMS

INTRODUCTION

To ensure your claim is processed efficiently, please follow the simple 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:** Describe your symptoms and date of diagnosis.
- **Supporting Documents:** Provide a copy of the pathology report confirming the diagnosis of cancer. If a biopsy was not performed due to the procedure being deemed medically contraindicated or posing an excessive risk, please provide us with all medical reports and test results that support the cancer diagnosis and staging.
- **Cancer Hospitalization, Outpatient Surgery and Treatments Details:**
 - Have the hospital's health records complete the "Record of Hospital Care for Cancer" form (page 6):
 - **For hospitalization:** with admission and discharge dates, unit of hospitalization, diagnosis and hospital stamp. Provide confirmations from each hospital if admitted to multiple facilities.
 - **For Outpatient Surgery/Treatment:** with dates of each Chemotherapy/Radiotherapy or outpatient surgeries.
 - For the home administered Chemotherapy, please provide the pharmacy receipts and the protocol of treatment from the attending physician.
- **Performance Status:** Please check the boxes that apply to your status and the period.
 - **Unemployed/retired:** describe your daily activities prior to your disability.
 - **Employment Confirmation:**
 - **Employees:** Have your employer confirm your absence due to disability (page 5).
 - **Self-Employed:** State the nature of your occupation and daily duties.
- **Authorization:** Sign and date the authorizations (pages 2 and 4) to allow us to obtain further 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*).

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 admission and discharge dates.
- **Performance Status:** Check the boxes that apply to your functional status.
- **Physician Details:** Provide the full address and phone number of the oncologist.
- **Family Physician:** Provide the full address and phone number of the family physician.

SUBMISSION

- **Make Copies:** Keep a copy of both sides of the claim form. Note the date sent for your records.
- **Send Completed Forms To:**
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: <https://my.combinedinsurance.com/en-CA/login>

AGENT AUTHORIZATION

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

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

SECTION 1 - CLAIMANT'S INFORMATION

LAST NAME		FIRST NAME		PRIMARY INSURED/OWNER <input type="checkbox"/>		DEPENDENT <input type="checkbox"/>	
MAILING ADDRESS				STREET		APT. #	
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH	MM	DD	YYYY	POLICY NUMBER(S)
PRIMARY PHONE		ALTERNATE PHONE					
EMAIL				PREFERRED METHOD OF CONTACT			
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.				PHONE <input type="checkbox"/>	MAIL <input type="checkbox"/>	EMAIL <input type="checkbox"/>	

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

SECTION 2 - MEDICAL & EMPLOYMENT DETAILS

DIAGNOSIS	DATE OF FIRST SYMPTOMS	MM	DD	YYYY
DATE THAT YOU FIRST SOUGHT MEDICAL CARE FOR THIS CONDITION		MM	DD	YYYY
NAME OF DOCTOR YOU CONSULTED	NAME OF FAMILY DOCTOR			
AT THE TIME OF YOUR LOSS WERE YOU	EMPLOYED <input type="checkbox"/>	SELF-EMPLOYED <input type="checkbox"/>	RETIRED/UNEMPLOYED <input type="checkbox"/>	STUDENT/CHILD <input type="checkbox"/>

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

SECTION 3 - PERFORMANCE STATUS

- Fully active, able to carry on all pre-symptom/diagnosis performance without restriction.
- Restricted in physically strenuous activity but ambulatory (i.e. actively mobile) and able to carry out work at light or sedentary nature.
- Ambulatory (i.e. actively mobile) 50% of the time and capable of all selfcare but unable to carry out any work activities.
- Capable of only limited selfcare, confined to bed or chair more than 50% of the time.
- Cannot carry on selfcare. Totally confined to bed or chair.

FROM _____ TO _____

EXPECT OR ACTUAL DATE OF RETURN TO FULLY ACTIVE STATUS MM DD YYYY

SECTION 4 - CONSENT & 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 to 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)
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ATTENDING PHYSICIAN'S STATEMENT

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

SECTION 1 - PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____ MM DD YYYY

SECTION 2 - DIAGNOSIS

- a. What is the primary diagnosis/condition _____
Attach objective findings (including the pathology report).
- b. Date of first symptoms (MM/DD/YYYY) _____
- c. Has patient ever had same or similar condition? NO YES Provide details _____
- d. Secondary contributing conditions _____

SECTION 3 - PHYSICIANS AND FOLLOW-UP

- a. Name of FAMILY physician _____
- b. Name of ONCOLOGIST _____
- 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) _____

SECTION 4 - HOSPITALIZATION AND TREATMENT

- a. Name of hospital where treated _____
- EMERGENCY ROOM:
Arrival Date & Time (MM/DD/YYYY) _____ Departure Date & 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, dosage, administration and course):

SECTION 5 - PERFORMANCE STATUS

- Fully active, able to carry on all pre-symptom/diagnosis performance without restriction.
- Restricted in physically strenuous activity but ambulatory (i.e. actively mobile) and able to carry out work at light or sedentary nature.
- Ambulatory (i.e. actively mobile) 50% of the time and capable of all selfcare but unable to carry out any work activities.
- Capable of only limited selfcare, confined to bed or chair more than 50% of the time.
- Cannot carry on selfcare. Totally confined to bed or chair.

FROM _____ TO _____

EXPECT OR ACTUAL DATE OF RETURN TO FULLY ACTIVE STATUS _____ MM DD YYYY

SECTION 6 - DOCTOR SIGNATURE & INFORMATION

Name of attending physician (please print) _____ Specialty _____

Address _____ Fax _____ Telephone _____

Signature _____ License _____ Date _____

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 to 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.

Signed on the _____ day of _____ 202_____

Name of claimant/insured: _____
(please print)

Date of birth: _____

Signature of claimant/insured: _____
If claimant/insured is a minor see below

Name of parent/guardian: _____
(please print)

Signature of parent/guardian: _____

EMPLOYER'S CERTIFICATE

SECTION 1 - WORK ABSENCE INFORMATION

I hereby certify that _____
FIRST MIDDLE LAST

Was absent from work from _____ to _____ (Inclusive)
MM/DD/YYYY MM/DD/YYYY

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

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

SECTION 2 - OCCUPATION INFORMATION

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

SECTION 3 - EMPLOYER'S IDENTIFICATION

Company name _____

Company address _____

Authorized person's name & job title _____

Authorized person's contact information _____

Authorized person's signature _____ Date _____
MM/DD/YYYY

RECORD OF HOSPITAL CARE FOR CANCER

TO BE COMPLETED BY THE HEALTH RECORDS

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

Patient's Name _____
FIRST
MIDDLE
LAST

CARE UNIT	ADMISSION DATE <small>MM/DD/YYYY</small>	DISCHARGE DATE <small>MM/DD/YYYY</small>
Emergency	_____	_____
Intensive Care	_____	_____
Active Care	_____	_____
Palliative, Extended or Convalescence Care	_____	_____
Other Units (please describe)	_____	_____

SURGERY <small>MM/DD/YYYY</small>	OUTPATIENT CHEMOTHERAPY <small>MM/DD/YYYY</small>	HOME ADMINISTERED CHEMOTHERAPY <small>MM/DD/YYYY</small>	RADIATION <small>MM/DD/YYYY</small>
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Do not include follow-up and lab visits or pre-treatment appointments

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature & stamp of department official

Date

Hospital

Signature

Printed Name

Telephone

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 keypad, 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.

Primary Insured/Owner (Print Name)

Primary Insured/Owner Signature

E-mail Address

Date

**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:

- 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.
- 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.
- 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.
- Failed or Expired Transactions:** The payment will default to a cheque after three (3) calendar days of receiving this email.