BLUE CROSS®
CANASSURANCE

Accidental Loss of Use or Dismemberment

Claimant's Statement

The form must be submitted to the insurer within 90 days of the accidental loss.

IDENTIFICATION

Claimant's Name: ______________________ Policy No.: ______________________

Date of Birth: day/month/year Public Health Card No.: ______________________

Address: ______________________

Home Phone: ____________ Mobile: ____________ E-mail: ______________________

Name of the policyholder: ______________________

ACCIDENT INFORMATION

Please provide as many details as possible.

Date: day/month/year Time: _____ : _____ ❑ AM ❑ PM

Location of accident (Indicate, if possible, street address and type of location: residence, public building, roadway, job site, etc.):

____

____

Circumstances (Explain how the accident occurred): ______________________

____

____

Name(s) of witnesses: ______________________

____

Was a police report provided? ❑ Yes ❑ No If yes, please attach a copy.

In case of a road accident, has a claim been filed with another insurance company, public or private? ❑ Yes ❑ No If yes, please provide:

Name of the insurer: ______________________ File number (if known): ____________

Name(s) of witnesses: ______________________

Was a police report provided? ❑ Yes ❑ No If yes, please attach a copy.

STATEMENT

I hereby certify that the above information is, to the best of my knowledge, true and complete.

______________________ day/month/year
Signature of claimant Date

____
Signature of the policyholder if claimant is less than 16 years of age in Ontario or less than 14 years of age in Québec.

Please read the IMPORTANT NOTICE on the back of the form.

IMPORTANT NOTICE

The forms gathered in this document are required when a claim is filed for the **Accidental Loss of Use or Dismemberment** benefit. All questions must be answered and the form must be submitted to the insurer within 90 days of the accidental loss. If the claim is related to an accidental death, the forms are gathered in the DEATH CLAIM FORM.

CLAIMANT'S STATEMENT

- Sections IDENTIFICATION, ACCIDENT INFORMATION and STATEMENT must be completed.
- If a claim has been filed with another insurer, public or private, provide the relevant information in the section ACCIDENT INFORMATION.
- Fees requested to complete this form are paid by the claimant.

ATTENDING PHYSICIAN'S STATEMENT

- The section IDENTIFICATION must be completed by the insured person and the form must be completed by the physician.
- A photocopy of the clinical notes and/or operative procedure must be attached to the completed form.
- Fees requested to complete this form are paid by the claimant.

Important
No comments must appear in the section completed by the physician and his/her notes must not be modified. To provide any details or comments to the information given, a separate sheet must be used.

AUTHORIZATION

- Read the content of the authorization carefully in order to understand the implications. This form will be used to collect the information required for the process of the claim or to disclose information to third parties.
- All three authorizations must be dated and signed in order to avoid any delay in the process.
- A blue ink ball point pen is preferable as some hospitals may mistake a form signed using black ink for a photocopy.

Forward the claim to the appropriate address according to the province of residence. For any questions, contact the Claims Department by telephone prior to forwarding the claim in order to avoid unnecessary delays. Calls to our Claims Department are recorded for training, quality control and verification purposes.

Blue Cross Canassurance
Claims, Life and Disability Insurance
Telephone: 1 800-300-5002
Fax: 1 877-590-7504

Address in Ontario
P.O.Box 4433, Station A
Toronto, Ontario M5W 3Y7
Email: claimslife.disability@ont.bluecross.ca

Address in Québec
1981 McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
Email: claimslife.disability@qc.bluecross.ca

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Accidental Loss of Use or Dismemberment

Attending Physician's Statement

PATIENT'S IDENTIFICATION (section to be completed by the claimant)

Last Name: ______________________ First Name: ______________________

Date of Birth: day/month/year Policy No.: ______________ Public Health Insurance Card No.: ______________

ATTENDING PHYSICIAN'S STATEMENT (to be completed in block letters and given to the patient)

DIAGNOSTIC

1. Primary: ______________________ Code CIM-9: ______________________
2. Secondary: ______________________ Code CIM-9: ______________________
3. Date of the accident: day/month/year
4. Date of the first consultation for this condition: day/month/year
5. Does or will the patient undergo:
   a) exams or tests? ❑ yes ❑ no Specify: ______________________
   b) a surgery? ❑ yes ❑ no Name of surgery: ______________________
   Date of surgery: day/month/year
   c) an hospitalization? ❑ yes ❑ no Dates of hospitalization: from day/month/year to day/month/year
   Name of hospital: ______________________
6. To your knowledge, does this patient suffer from any illness susceptible to have caused the loss, in whole or in part? ❑ yes ❑ no
7. If yes, what condition(s) is the patient suffering from? ______________________
8. Since when? day/month/year
9. Other comments: ______________________

Please attach a photocopy of the clinical notes and/or the operative procedure.

STATEMENT

First and Last Name: ______________________ Telephone: ______________

Address: ______________________ Fax: ______________

❑ General practitioner ❑ Specialist Specify: ______________ Licence No.: ______________

Signature ______________________ Date day/month/year

Note: The claimant must pay any fees to complete this form.

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Authorization

IDENTIFICATION

Name of claimant: ______________________________

Policy No: ______________________________ Date of birth: day / month / year

Name of the policyholder: ______________________________

To assess and determine my eligibility with respect to insurance products and benefits, I hereby authorize any physician, health professional, hospital, medical establishment, insurance company or reinsurer, the Medical Information Bureau (MIB) or other organization, institution, employer, broker, agent, representative or other individual in the possession of information about me or my state of health, including my medical history, to convey or transmit this information to Canassurance Hospital Service Association or Canassurance Insurance Company (hereinafter referred to as the 'Insurer'), or reinsurer, internal or external auditors, as well as any professional or organization mandated by the Insurer for the purpose of processing of my claim.

I hereby authorize Canada Pension Plan (CPP), Québec Pension Plan (QPP), Human Resources and Skills Development Canada (HRSDC), *Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)*, Workplace Safety and Insurance Board of Ontario (WSIB), *Régie de l'assurance maladie du Québec (RAMQ), Société de l'assurance automobile du Québec (SAAQ)* and any other federal or provincial organization or board to convey to the Insurer administrative, medical and pharmacological information about me.

In addition, I hereby authorize the Insurer to share information about me with the aforementioned individuals and organizations. This authorization shall be valid for the duration of my disability claim.

______________________________ day / month / year
Signature of claimant Date

____
Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec

01VRS0016A (03-2020)

BLUE CROSS®
CANASSURANCE

Authorization

IDENTIFICATION

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Policy No: ______________________________ Date of birth: day / month / year

Name of the policyholder: ______________________________

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01VRS0016A (03-2020)