

# 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 last name	Claimant's first name	Policy No.
Date of Birth (DD-MM-YYYY)	Public Health Card No.	
Address		
Home Phone	Mobile	E-mail
Name of the policyholder		

## ACCIDENT INFORMATION

Please provide as many details as possible.

Date (DD-MM-YYYY)	Time	<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide:		
Name of the insurer	File number (if known)	
Name(s) of witnesses		
Was a police report provided? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

\_\_\_\_\_  
Signature of claimant

\_\_\_\_\_  
Date (DD-MM-YYYY)

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

## 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 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 for 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**

#### Address in Ontario

P.O. Box 4433, Station A

Toronto, Ontario M5W 3Y7

Secure Website : [on.bluecross.ca/depot](https://on.bluecross.ca/depot)

#### Address in Québec

1981 McGill College Avenue, Suite 105

Montreal, Quebec H3A 0H6

Secure Website : [qc.bluecross.ca/depot](https://qc.bluecross.ca/depot)

# ACCIDENTAL LOSS OF USE OR DISMEMBERMENT

## Attending Physician Statement

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

Last name	First name	Policy No.
Date of Birth (DD-MM-YYYY)	Public Health Card No.	

### ATTENDING PHYSICIAN'S STATEMENT (to be completed and given to the patient)

#### DIAGNOSTIC

1. Primary diagnosis	Code CIM-9
2. Secondary diagnosis	Code CIM-9
3. Date of the accident (DD-MM-YYYY)	4. Date of the first consultation for this condition (DD-MM-YYYY)
5. Does or will the patient undergo	
a) exams or tests? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify
b) a surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of surgery
	Date of surgery (DD-MM-YYYY)
c) an hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates of hospitalization: from (DD-MM-YYYY) to (DD-MM-YYYY)
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. If yes, what condition(s) is the patient suffering from?	
8. Since when? (DD-MM-YYYY)	
9. Other comments	

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

### STATEMENT

Last name	First name	Telephone
Address		Fax
<input type="checkbox"/> General practitioner <input type="checkbox"/> Specialist	Please specify	Licence No.
Signature		Date (DD-MM-YYYY)

## IDENTIFICATION

Last name of claimant		First name of claimant	Policy No.
Date of birth (DD-MM-YYYY)		Name of the policyholder	
<p>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 MIB, Inc. 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, or Blue Cross Life Insurance Company of Canada (hereinafter jointly 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.</p> <p>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.</p> <p>This authorization shall be valid for the duration of my disability claim.</p>			
Signature of claimant		Date (DD-MM-YYYY)	
Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec			

01VRS0016A (2022-03)

## IDENTIFICATION

Last name of claimant		First name of claimant	Policy No.
Date of birth (DD-MM-YYYY)		Name of the policyholder	
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Signature of claimant		Date (DD-MM-YYYY)	
Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec			

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## IDENTIFICATION

Last name of claimant		First name of claimant	Policy No.
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Signature of claimant		Date (DD-MM-YYYY)	
Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec			

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