COMBINED INSURANCE

COMBINED INSURANCE COMPANY OF AMERICA
COMPAGNIE D'ASSURANCE COMBINED D'AMÉRIQUE

CANADIAN HEAD OFFICE P.O. BOX 3720 MIP, MARKHAM, ON L3R 0X5
TELEPHONE: 1 888 234-4466 • www.combined.ca

COMBINED ASSURANCES

This form must be fully completed and returned within 90 days of the loss

CLAIMANT'S STATEMENT

PLEASE PRINT

NAME OF INSURED: LAST NAME / GIVEN NAME			SPOUSE'S NAME	TELEPHONE
MAILING ADDRESS: STREET		APT. #	PREFERRED METHOD OF CONTACT: MAIL ☐ EMAIL ☐	POLICY NUMBER(S) a)
CITY	PROVINCE	POSTAL CODE	EMAIL	b)
BIRTHDATE MM DD YYYY / AGE	SEX M ☐ F ☐		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.	c)

If insured is a minor, please provide the name of a legal guardian/parent who resides with child. Provide any relevant information (custody order or legal guardianship), if applicable.

Address of legal guardian if different from minor

COMPLETE FOR ACCIDENT

Date of accident (MM/DD/YYYY)	Time ☐ AM ☐ PM	Location	Injuries sustained
Please describe in detail how accident occurred (Attach diagram or extra sheet if necessary)			

COMPLETE FOR SICKNESS

Date of first symptoms (MM/DD/YYYY)	Have you ever had same or similar condition? If "Yes", give date (MM/DD/YYYY) Yes ☐ Date _____ No ☐
Nature of sickness	

COMPLETE IF YOU ARE SELF EMPLOYED

Occupation/Name of your business
Job description

COMPLETE IF YOU ARE UNEMPLOYED OR RETIRED

Describe your usual daily activities prior to the onset of your accident or sickness

COMPLETE FOR ACCIDENT OR SICKNESS

Dates during which you were unable to do all the duties pertaining to your usual occupation or perform your usual daily activities. First day of total disability: (MM/DD/YYYY) Last day of total disability: (MM/DD/YYYY)		
Dates during which you were able to perform part of the duties pertaining to your usual occupation or perform part of your usual daily activities. First day of partial disability: (MM/DD/YYYY) Last day of partial disability: (MM/DD/YYYY)		
Are you still totally disabled? Yes ☐ No ☐		
Your doctor's name and address	Hospital name and address	Date of confinement (MM/DD/YYYY) - Admission date: - Discharge date:

Protecting your Personal Information At Combined Insurance, we recognize and respect the importance of privacy. Personal information that we collect, store, and disclose is used for the purposes of investigating, assessing and administering your claim(s). For a copy of our Privacy brochure, or if you have any questions about our personal information policies and practices (including with respect to service providers), write to our Chief Privacy Officer or refer to www.combined.ca.

Authorization and Declaration I have read, understand and agree with the contents of the section entitled "Protecting your Personal Information" on this form. I authorize Combined Insurance, any healthcare provider, any insurance or reinsurance company, administrators of government benefits or other benefits programs, or any person having knowledge of me or my health, other organizations or service providers working with Combined Insurance, located within or outside Canada, to exchange personal information when relevant for the purposes of investigating, assessing and administering my claim(s). This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me in writing. I certify that the information contained in this form is true and accurate. I understand that it is an offence under the Insurance Act to knowingly make any fraudulent, false or misleading statements or representations to an insurer under a contract of insurance. I understand that if Combined Insurance finds that I have provided fraudulent information or made any false or misleading statements, Combined Insurance may, in its discretion, deny the claim and/or rescind the policy.

Signature of insured	Date (MM/DD/YYYY)

IMPORTANT: Review your claim form. Is it complete? A form not fully completed may delay settlement of your claim. Also retain a copy of both sides of your completed claim form.

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ATTENDING PHYSICIAN'S STATEMENT

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

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

1. Diagnosis of present condition (specific medical diagnosis)
   (a) Primary Diagnosis _____
   (b) Additional conditions or complications _____
   (c) Objective findings (including results of x-rays, laboratory data or any other special tests). Attach all test results/specialist reports. _____
   _____
2. If condition is due to pregnancy, what is the expected delivery date? _____
3. If this condition is due to:
   (a) **Sickness** – Date symptoms first appeared (MM/DD/YYYY) _____
   Has patient ever had same or similar condition? Yes ☐ If "Yes", state when and describe under section10.
   No ☐
   (b) **Accident (Injury)** – Date accident happened (MM/DD/YYYY) _____
   (c) How did condition/injury originate? _____
   _____
4. (a) If patient was referred to you, give complete name of referring physician _____
   (b) If you have referred patient to a specialist, give complete name(s) of physician(s) _____
   _____
5. (a) Date patient first consulted for present condition (MM/DD/YYYY) _____
   (b) Date of last visit (MM/DD/YYYY) _____
   (c) Were you actively supervising patient's care during full period?
   Yes ☐ Frequency: weekly ☐ monthly ☐ Other (Specify) _____
   No ☐ If "No", please comment under section10.
6. Name of hospital where treated _____
   (a) Emergency Room – Admission Date and Time (MM/DD/YYYY) _____ Discharge Date and Time (MM/DD/YYYY) _____
   (b) Inpatient Hospital Confinement – Admission Date (MM/DD/YYYY) _____ Discharge Date (MM/DD/YYYY) _____
7. Nature of Treatment (e.g. date and type of surgery, including medication)_____
   _____
8. To the best of my knowledge,
   (a) The patient has been totally disabled (unable to work or perform daily activities) from _____ to _____ inclusive.
   (b) The patient has been partially disabled (able to perform some duties at work or some daily activities) from _____ to _____ inclusive.
   (c) What are the restrictions and limitations preventing patient from returning to work or doing daily activities?_____
   _____
   If still unable to work or perform daily activities, give approximate date when patient should be able to return to work or perform daily activities.
   _____
9. If patient is a student, what are the restrictions and limitations affecting his/her daily activities? _____
   _____
10. Please provide any other information that would be helpful in the assessment of your patient's claim _____
    _____
    _____

Name of attending physician (please print) _____ Specialty _____

Address _____ Telephone _____

Signature _____ Date_____

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CERTIFICATE OF EMPLOYER

I hereby certify that: MR. ☐ MRS. ☐ MS. ☐ MISS ☐

_____

First Middle Last

Day/Month/Year **Day/Month/Year**

Was absent from work from: _____ to _____(Inclusive)

He (she) was first able to resume part of his (her) duties on: _____

And all of his (her) duties on: _____

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

Is this person receiving 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.

Company Stamp (with full name, address and telephone number)

Name Position

Signature of Employer

Telephone No. Fax No.

Date

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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 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.

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.

_____ _____

Print Name Signature

_____ _____

E-mail Address Date