



CLAIM REQUEST – INDIVIDUAL INSURANCE  
ACCIDENTAL FRACTURE

CLAIMANT’S STATEMENT

POLICY NO: \_\_\_\_\_

First and Last Name of the injured: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Telephone Number: ( ) \_\_\_\_\_ Work Telephone Number: ( ) \_\_\_\_\_

**DETAILS REGARDING THE ACCIDENT**

1. Date of the accident: \_\_\_\_\_

2. Time of the accident: \_\_\_\_\_

3. Location of the accident: \_\_\_\_\_

4. Type of accident:

a) Work related accident: \_\_\_\_\_

b) Motor vehicle accident: \_\_\_\_\_

**If yes, were you the driver or passenger of the vehicle?** \_\_\_\_\_

c) Sport injury: \_\_\_\_\_

Were you remunerated for your participation in this sport? \_\_\_\_\_

d) Other, specify: \_\_\_\_\_

5. Please provide a complete description of the circumstances leading to the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Were you alone or with others? \_\_\_\_\_

If with others, please provide the names, addresses and phone numbers of the others: \_\_\_\_\_  
\_\_\_\_\_ Postal Code \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

7. Had you consumed any alcoholic beverages before the accident? \_\_\_\_\_ **If yes, how many?** \_\_\_\_\_

**IF THE INJURIES OCCURRED AS A RESULT OF A MOTOR VEHICLE ACCIDENT AND YOU WERE THE DRIVER, PLEASE INCLUDE A COPY OF THE POLICE REPORT.**

**I DECLARE THAT ALL INFORMATION STATED ABOVE IS COMPLETE AND TRUE.**

X \_\_\_\_\_

X \_\_\_\_\_

**POLICY OWNER SIGNATURE**

**DATE**



MEDICAL STATEMENT – INDIVIDUAL INSURANCE ACCIDENTAL FRACTURE

ATTENDING PHYSICIAN STATEMENT

POLICY NO: \_\_\_\_\_

Any fee for completing this form is the claimant's responsibility.

First and Last Name of the Injured: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_

DETAILS REGARDING THE ACCIDENT

1. Date of the Accident: \_\_\_\_\_

2. Date of the first consultation following the accident: \_\_\_\_\_

3. Type of Accident:

- a) Work: [ ] b) Motor Vehicle Accident [ ]
c) Sport: [ ] d) Other, specify: \_\_\_\_\_

4. Among the injuries, is there any fracture(s)? Specify: \_\_\_\_\_

5. Do you notice any contusion(s) or lesion(s) on the body surface where the fracture occurred? Specify: \_\_\_\_\_

PLEASE ATTACH A COPY OF THE X-RAY PROTOCOL

6. Where the injury (ies) a result of a fight or public disturbance? \_\_\_\_\_

7. Was the accident a result of a voluntary or involuntary use of drug(s), substance(s) or toxic gas? \_\_\_\_\_

8. Was a blood test done in order to determine the level of alcohol in the blood? If yes, provide the result \_\_\_\_\_

9. Name and address of the attending physician (In capital letters) Speciality: Licence number:

X ATTENDING PHYSICIAN SIGNATURE DATE



**AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL  
INFORMATION TO A THIRD PARTY**

In order to assess insurability, maintain our file and claims assessment, we authorize any person or institution holding personal information about us including any health information, medical history or eligibility for claims, to transmit such information to UL Mutual or its reinsurers upon request. This includes doctors or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, the Medical Information Bureau, personal information agencies, financial advisors, any financial institution, the policy owner, our employer or previous employer, the Commission de santé et sécurité du travail or other Workmen's Compensation Board, Canada or Quebec Pension Plan, Société de l'assurance automobile du Québec or other Department of Motor Vehicles, la Régie de l'assurance médicaments du Québec or other provincial Health Department, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Likewise, we authorize UL Mutual to transmit the information to its reinsurers as well as to a third party. For the same purpose and to gather the same type of information, we also authorize **UL Mutual** or its reinsurers to request an investigative report about us and to use information in their possession in other files. This consent is also valid for gathering, use and transmission of personal information concerning our minor children. No modification or alteration of this consent will affect its content nor bind the insurer. This consent may also be used for a request for additional insurance or a contract modification.

**A photocopy of this agreement shall be as valid as the original.**

Signed at \_\_\_\_\_, this \_\_\_\_\_ 20 \_\_\_\_\_

X \_\_\_\_\_  
**WITNESS**

X \_\_\_\_\_  
**SIGNATURE**

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_