MUTUAL

CLAIMANT'S STATEMENT– INDIVIDUAL INSURANCE ACCIDENTAL DISMEMBERMENT, ACCIDENTAL LOSS OF SIGHT OR PARALYSIS RESULTING FROM AN ACCIDENT

CLAIMANT'S STATEMENT **POLICY NUMBER**: _____

This form must be completed by the insured person, if 14 years or older. Otherwise, or if the insured person is unable to, the father, mother, legal guardian or legal representative of the insured person can complete it.

Last name and first name of the insured person	Date of birth _____/_____/_____ Year Month Day	Sex ☐ F ☐ M
Address of the insured person _____ _____		Home Telephone No. : (____)_____ Work Telephone No. : (____)_____

Date of accident _____/_____/_____ Year Month Day	Time of accident _____ ☐ AM ☐ PM	Place of accident _____

Description of the circumstances of the accident _____

_____

_____

Type of accident

☐ work related ☐ motor vehicle ☐ sport ☐ _____
Other, please specify

Nature of injuries

_____

Attending physicians

_____ _____

Name and address Name and address

Did the injuries require any surgical intervention? - If yes, provide the date and complete details: _____

_____

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

X_____ _____

SIGNATURE OF THE INSURED PERSON (14 YEARS OR OLDER) DATE

_____ _____

CLAIMANT'S LAST AND FIRST NAME (IF CLAIMANT IS NOT THE INSURED PERSON) RELATIONSHIP TO INSURED PERSON

_____

CLAIMANT'S ADDRESS (IF CLAIMANT IS NOT THE INSURED PERSON)

X_____ _____

CLAIMANT'S SIGNATURE DATE

MUTUAL

MEDICAL STATEMENT– INDIVIDUAL INSURANCE
ACCIDENTAL DISMEMBERMENT, ACCIDENTAL LOSS OF SIGHT OR PARALYSIS RESULTING FROM AN ACCIDENT

POLICY NUMBER: _____

ATTENDING PHYSICIAN STATEMENT

The fee required to fill this form is the claimant's responsibility.

1- Last Name - First Name:	2- Date of Birth _____/_____/_____ Year Month Day
3- Date of Accident _____/_____/_____ Year Month Day	4- Type of Accident ☐ Work ☐ Motor Vehicle ☐ Sport Specify: _____

5 –Was the injury, or complication of treatment thereof, suffered by the person under the influence of narcotics or alcohol, or upon consuming an overdose of hallucinogens or drugs not prescribed by a physician, or poison, gas or gasoline? ☐ Yes ☐ No

If yes, please provide details and results of tests : _____

6- A) Description of the loss _____

B) Does the loss result solely and directly from injuries sustained as the result of the accident? ☐ Yes ☐ No

C) Degree of amputation or percentage of loss of use	Date of loss
_____	_____/_____/_____ Year Month Day

7 - Is the loss of use complete and irrecoverable?	**Loss**	**Left**	**Right**
☐ Yes ☐ No	☐ Eye	☐ Yes ☐ No	☐ Yes ☐ No
If yes, since when? _____	☐ Hand	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Foot	☐ Yes ☐ No	☐ Yes ☐ No
	☐ _____	☐ Yes ☐ No	☐ Yes ☐ No

Loss of sight

8 - A) At the last consultation: Date _____	**Left eye**	**Right eye**	9 - Is the loss of use a direct result of the accident and is it independent of any other causes? ☐ Yes ☐ No - **If no**, please explain _____ _____ _____
1. Visual acuity			
2. Visual acuity with glasses			
B) The vision can be entirely or partially corrected with:	☐ Glasses ☐ Treatments ☐ Surgery ☐ None	☐ Glasses ☐ Treatments ☐ Surgery ☐ None	

Paralysis

10 – Has the accident caused:	11- A) Date on which the paralysis occurred? _____
☐ quadriplegia?	B) Is the accident the only cause of paralysis? ☐ Yes ☐ No
☐ paraplegia?	C) If the paralysis is not a result of the accident, please provide a brief outline of the medical history leading to the paralysis:_____
☐ hemiplegia ?	_____
	D) Is the paralysis permanent, total and irremediable? ☐ Yes ☐ No

	Name	Address	Date
12- A) Other Attending Physician(s):	_____	_____	_____
	_____	_____	_____
B) Hospital, Sanatorium, or any other medical institutions:	_____	_____	_____
	_____	_____	_____

13- Comments	_____	
14- Name and Address of the Physician (capital letters)	_____ _____	Speciality:_____ Licence Number: _____

X _____ _____

SIGNATURE OF THE PHYSICIAN **DATE**

EQC029 (14-03)

MUTUAL

AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

For the sole purpose of managing files and processing claims, we authorize any person or institution holding personal information about us including, but not limited to, any health information, medical history or eligibility for claims, to transmit such information to UL Mutual or its reinsurers upon request. This includes, but is not limited to, doctors or other practitioners, hospital, medical clinic or paramedical companies, laboratories, insurance companies or reinsurers, the MIB Inc., personal information agencies, financial advisors, any financial institution, the policy owner, our employer or previous employer, the CSST or other Workers' Compensation Board, Canada or Quebec Pension Plan, the SAAQ or other Department of Motor Vehicles, the RAMQ 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 authorization is also valid for the gathering, use and transmission of personal information concerning our minor children. No modification or alteration of this authorization will affect its content nor bind the insurer.

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

X _____ _____

SIGNATURE OF THE INSURED PERSON (14 YEARS OR OLDER) DATE

_____ _____

CLAIMANT'S LAST AND FIRST NAME (IF CLAIMANT IS NOT THE INSURED PERSON) RELATIONSHIP TO INSURED PERSON

_____

CLAIMANT'S ADDRESS (IF CLAIMANT IS NOT THE INSURED PERSON)

X _____ _____

CLAIMANT'S SIGNATURE DATE