MUTUAL

CLAIMANT'S STATEMENT – CRITICAL ILLNESS

Name: _____ First Name: _____

Policy Number: _____ Date of Birth: _____/_____/_____
D M Y

Address: _____

Postal Code:_____ Provincial Health Insurance Plan Number: _____

Telephone Number: ***Home:*** ( ) ***Office:*** ( )

Occupation: _____ Date of your last day of work: _____/_____/_____
D M Y

Date symptoms first appeared: _____/_____/_____
D M Y

Date of diagnosis: _____/_____/_____
D M Y

Date that you have been informed of the diagnosis: _____/_____/_____
D M Y

1. **Please give us the details about the nature and extent of the illness:**

   _____

   _____

   _____

2. **Date of your first medical consultation for this illness:** _____

3. **Name and address of the consulted physician:** _____

   _____

   _____

4. **Was he (she) your usual attending physician?** Yes ❑ No ❑

   If no, who referred you to this physician? _____

   Date of the first treatments for this illness? _____

5. **Have you previously suffered from or received treatment for a related illness?** Yes ❑ No ❑

   If yes, please indicate the details and the dates:

   _____

   _____

6. **Please indicate what treatment you are currently receiving including the details and dates of all tests made in a hospital or clinic and of all treatments received.**

   _____

   _____

   _____

7. **Has any of your family members suffered from a related illness?** Yes ❑ No ❑

   If yes, please tell us what is your relationship with this person, the type of illness as well as the age at which the illness was diagnosed.

   _____

   _____

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8. **Do you smoke?** Yes ❑ No ❑ **If yes**, what is your daily consumption? _____

How long have you been smoking? _____

_____

_____

If no, have you ***ever*** smoked and if so, what was your daily consumption at that time and how long have you stopped?

_____

_____

_____

9. **Please give the names, addresses and telephone numbers of all physicians who have treated you or hospitals where you were treated for the illness (specify the dates and reasons for your visits):**

_____

_____

_____

_____

10. **If not indicated above, please provide the name, address and the telephone number of your family doctor:**

Name: _____

Address: _____

_____ Postal Code _____

Telephone: ( ) _____

DECLARATION/ILLNESS

I declare that the information given on the claim form is true and complete. For the purposes of administration of my file and study claims, I authorise 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, hospital, medical clinic 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 Workers' 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, I also authorise UL Mutual to transmit the information to its reinsurers as well as to a third party.

I understand that a copy of this agreement, which is valid for the duration of this claim, has the same value as the original.

I understand that the completed form does not constitute approval of the claim by the Company.

X _____ _____

INSURED'S SIGNATURE **DATE**

MUTUAL

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 Workers' 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 _____ **X** _____

WITNESS **SIGNATURE**

ADDRESS _____

_____

_____