

CLAIM #	

**COMBINED INSURANCE COMPANY OF AMERICA**

**CANADIAN HEAD OFFICE  
P.O. BOX 3720 MIP  
MARKHAM, ON L3R 0X5**

**This form to be fully completed and returned within 60 days**

**CLAIMANT'S STATEMENT  
PLEASE PRINT**

NAME OF INSURED LAST NAME		GIVEN NAME		TELEPHONE		POLICY NUMBER(S) a)		FORM NUMBER(S) a)			
NUMBER		STREET		APT. #		WEIGHT		b)			
CITY		PROV.		POSTAL CODE		HEIGHT		c)			
BIRTHDATE M      D      Y		AGE		SEX M <input type="checkbox"/> F <input type="checkbox"/>		SPOUSE'S NAME		d)			
OCCUPATION		TYPE OF WORK				e)		e)			
<b>PLEASE COMPLETE FOR ACCIDENT</b>	DATE ACCIDENT		TIME AM           PM		LOCATION		INJURIES SUSTAINED				
	PLEASE DESCRIBE IN DETAIL HOW ACCIDENT OCCURRED (ATTACH DIAGRAM OR EXTRA SHEET IF NECESSARY)										
<b>COMPLETE FOR SICKNESS</b>	DATE OF FIRST SYMPTOMS			HAVE YOU EVER HAD SAME OR SIMILAR CONDITION?			IF YES GIVE DATE				
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
NATURE OF SICKNESS											
IS THIS A WORKERS' COMPENSATION CLAIM?				YES <input type="checkbox"/> NO <input type="checkbox"/>		AS OF THIS DATE ARE YOU STILL TOTALLY DISABLED?				YES <input type="checkbox"/> NO <input type="checkbox"/>	

**COMPLETE FOR ACCIDENT OR SICKNESS**

DATES DURING WHICH I WAS UNABLE TO DO ALL THE DUTIES PERTAINING TO MY USUAL OCCUPATION:		FIRST DAY OF TOTAL DISABILITY	LAST DAY OF TOTAL DISABILITY
		_____	_____
DATES DURING WHICH I WAS ABLE TO PERFORM PART OF THE DUTIES PERTAINING TO MY USUAL OCCUPATION:		FIRST DAY OF PARTIAL DISABILITY	LAST DAY OF PARTIAL DISABILITY
		_____	_____

YOUR DOCTOR'S NAME AND ADDRESS		<b>CONFIRMATION FROM HOSPITAL IS A MUST FOR A HOSPITAL CLAIM</b>	
DATES OF TREATMENTS		HOSPITAL NAME AND ADDRESS	

EMPLOYER'S STATEMENT	NAME AND ADDRESS OF EMPLOYER	TELEPHONE NUMBER

FIRST DAY OF ABSENCE FROM WORK \_\_\_\_\_ RETURNED TO WORK \_\_\_\_\_ PARTIALLY DISABLED FROM \_\_\_\_\_ TO \_\_\_\_\_

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION** I hereby authorize any health care professional, as well as any public or private health or social service establishment, any insurer, my employer or former employer, Consumer reporting agency, any other organization or persons having records or information concerning me to furnish such records or information to the insurer and its reinsurer, particularly medical information, to determine eligibility for benefits. In case of death, the beneficiary, the heir or the liquidator of my estate is expressly authorized to supply the insurer, when required by the latter, with all the information and authorizations necessary to study the death benefit claim and obtain the required justifications. A photocopy of this authorization has the same value as the original.

DATE \_\_\_\_\_ Signature of Claimant \_\_\_\_\_

**IMPORTANT: Please review your claim form. Is it complete? A form not fully completed may delay settlement of your claim. Please also retain a copy of both sides of your completed claim form.**

# ATTENDING PHYSICIAN'S STATEMENT

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

Name of patient: \_\_\_\_\_

Date of birth: (M, D, Y) \_\_\_\_\_

1. Diagnosis of present condition (specific medical diagnosis)

(a) Primary \_\_\_\_\_

(b) Additional conditions or complications \_\_\_\_\_

(c) Objective findings (including current X-rays, laboratory data and any clinical findings) \_\_\_\_\_

2. If condition is due to pregnancy, what is the expected date of confinement? \_\_\_\_\_

3. To the best of my knowledge

(a) the sickness symptoms first appeared on (M, D, Y) \_\_\_\_\_ the accident occurred on (M, D, Y) \_\_\_\_\_

(b) has the patient had same or similar condition No  Yes  Please state when and describe (#10) \_\_\_\_\_

4. (a) If patient was referred to you, give name of referring physician \_\_\_\_\_

(b) If you have referred patient to a specialist, give name(s) of physician(s) \_\_\_\_\_

5. Date of hospital in patient - admission (M, D, Y) \_\_\_\_\_

Date of discharge (M, D, Y) \_\_\_\_\_

6. Nature of treatment (e.g. date and type of surgery, treatment including medication, dosage and frequency) \_\_\_\_\_

7. (a) Date of first visit for present condition (M, D, Y) \_\_\_\_\_

Date of latest attendance (M, D, Y) \_\_\_\_\_

(b) Were you actively supervising patient's care during full period

No

Comment in remark (#10) \_\_\_\_\_

Yes

Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Other (Specify) \_\_\_\_\_

8. (a) To the best of your knowledge, the patient has been unable to work at own occupation from \_\_\_\_\_ to \_\_\_\_\_

(b) The patient will be able to perform some duties of own occupation from \_\_\_\_\_ to \_\_\_\_\_

(c) If still unable to work, give approximate date patient should be able to return \_\_\_\_\_

(d) If not gainfully employed, can he/she perform his/her usual daily activities Yes  No  All  Some  None

or the estimate number of weeks before possible return \_\_\_\_\_

9. How does present condition affect patient's ability to work/perform usual activities - specific restrictions, (driving, bending, lifting, etc.), range of motion of affected area \_\_\_\_\_

10. Remarks. Please provide comments and further details which you feel would be helpful. \_\_\_\_\_

Name of attending physician  
(please print)

Specialty

Telephone no.

Address

Postal Code

Signature

Date