



COMBINED INSURANCE COMPANY OF AMERICA INSTRUCTIONS FOR FILING ACCIDENT AND HEALTH CLAIMS

If you are filing for disability and/or hospitalization, a claim form is required. To avoid delays, please answer all applicable questions on the claim form.

SIDE ONE TO BE COMPLETED BY THE CLAIMANT AND EMPLOYER

Please be sure to give complete name and address. Your payment and/or any correspondence will be mailed to the address unless we are directed to do so otherwise.

Write down all policy numbers.

If filing for loss due to sickness, fill in the first section of the form relating to your symptoms and diagnosis. For loss due to an injury, give us the requested information regarding the accident that caused the injury.

Please provide any reports to substantiate your diagnosis ie: outpatient surgery, Xray report, pathology etc..

If hospitalized, please have the hospitalization form fully completed and signed by the Health Records Department. If you were hospitalized in more than one hospital, please provide a confirmation from each hospital. The confirmation must contain:

- The admittance and discharge dates
- The unit or section in which you were hospitalized
- The hospital seal of the records department

If you are claiming for disability, please indicate the exact dates of partial and/or total disability.

If gainfully employed outside the home, the employer must verify your disability. If the Insured is a student, the school principal should complete this section.

If you are self-employed give us the nature of your occupation.

Please be sure to sign and date the authorization section located near the bottom of the form to enable us to obtain additional information, if necessary.

This will save processing time in the event that additional information is needed.

SIDE TWO TO BE COMPLETED BY DOCTOR

For a sickness or accident claim, the primary physician must complete the form, providing the diagnosis, how the condition originated, and the dates of treatment. If treated as an outpatient we need the service date. If treated as inpatient, you must provide confirmation of hospitalization from the Health Records Department of the hospital(s) attended.

Disability dates, both total and partial, must be indicated by the doctor. Please provide the doctor's complete address and phone number.

For your records, we suggest that you make a copy of both side of the claim form and of any bill(s) you submit. Note the date mailed. Mail the completed form and any enclosures to:

**COMBINED INSURANCE COMPANY OF CANADA
CLAIMS DEPARTMENT
P.O.BOX 3720 MIP
MARKHAM, ON L3R 0X5
Toll free number: 1-888-234-4466**

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)			
PLEASE COMPLETE FOR ACCIDENT	DATE ACCIDENT		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			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		CONFIRMATION FROM HOSPITAL IS A MUST FOR A HOSPITAL CLAIM	
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