

Please retain a copy of your completed claim form

CLAIMANT'S STATEMENT

(Please print)

Last Name		Given Name(s)		Telephone	Personal Policies with Combined if any:
Number	Street		Apt. #	Weight	
City	Province	Postal Code		Height	
Birthdate (MM/DD/YY) <input style="width: 100px; height: 20px;" type="text"/>		Age <input style="width: 50px; height: 20px;" type="text"/>	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Spouse's Name

PLEASE COMPLETE THIS PORTION ONLY IF YOUR CLAIM IS FOR ACCIDENT	Date of Accident (MM/DD/YY)	Time of Accident AM PM	Please state exactly where you were when the accident occurred		
	Please describe in detail how the accident occurred (attach an extra sheet, if necessary)				
	Injuries sustained			Have you had previous injuries of a similar nature? <input type="checkbox"/> Yes If yes, when? _____ <input type="checkbox"/> No	

PLEASE COMPLETE THIS PORTION ONLY IF YOUR CLAIM IS FOR SICKNESS	Date of First Symptoms (MM/DD/YY)	Have you ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide date(s) ... (MM/DD/YY)
	Description of the Sickness			

PLEASE COMPLETE THIS PORTION FOR ANY CLAIM (ACCIDENT OR SICKNESS)	Hospitalization Dates (confirmation from hospital required) (MM/DD/YY)	Hospital's name and address		
	Treatment Dates (MM/DD/YY)		Attending physicians' names and addresses	
	A) Total disability: unable to perform any duties: FROM: (MM/DD/YY) _____ TO: (MM/DD/YY) _____ 			
	B) Date of return to work (part-time or full-time): (MM/DD/YY) 			

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, and any other organization or persons having records of information concerning me to provide such records or information to Combined Insurance Company of America and its reinsurers, providing that such information is necessary to determine my eligibility for insurance benefits. In case of death, I hereby expressly authorize my beneficiary, heir or the liquidator of my estate to provide Combined Insurance Company of America, at its request, with all the information and authorizations necessary to assess my insurance benefit claim and obtain the required supporting documents. **A photocopy of this authorization has the same value as the original.**

DATE: _____

CLAIMANT'S SIGNATURE: _____

REGIONAL ADMINISTRATOR'S STATEMENT

Name and Address of the Sales Representative: _____	Telephone: () _____
_____	Annual Earnings: \$ _____

Is there a claim filed with the Workplace Safety and Insurance Board (WSIB)?

Yes No

TOTAL DISABILITY:

What is the last day the Sales Representative was in the field?

(MM/DD/YY)

Signature _____ Title _____ Date _____

OTHER DISABILITY BENEFITS

		Amount
a) Are you receiving disability benefits from WSIB? Yes <input type="checkbox"/> No <input type="checkbox"/>		\$ _____ /week (month)
b) Are you receiving Employment Insurance sickness benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		\$ _____ /week (month)
c) Are you receiving other disability benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Source: _____		\$ _____ /week (month)
_____		\$ _____ /week (month)
_____		\$ _____ /week (month)

REGULAR DUTIES

Position/Title: _____ Date of hire: _____

(MM/DD/YY)

DUTY	DESCRIPTION OF THE ACTIVITY INVOLVED	NUMBER OF HOURS SPENT WEEKLY AT EACH DUTY

**PLEASE ANSWER ALL QUESTIONS.
AN INCOMPLETE FORM COULD DELAY THE PROCESSING OF YOUR CLAIM.**

ATTENDING PHYSICIAN'S STATEMENT

(Please print)

Patient's Name _____ Date of Birth (MM/DD/YY) _____

1. History

- (a) When did symptoms first appear or accident happen? (MM/DD/YY) _____
- (b) Date patient ceased work because of disability? (MM/DD/YY) _____
- (c) Has patient ever had same or similar injury or condition? Yes No
 If Yes: Description of the condition or injury _____
- (d) Is this a work-related condition or injury? Yes No Unknown When: _____
- (e) Names and addresses of other treating physicians, if any: _____

2. Diagnosis

- I (a) Primary diagnosis _____
- (b) Secondary diagnosis (including complications) _____
- (c) Symptoms _____
- (d) Objective findings (incl. current X-Rays, EKGs, laboratory data and any clinical findings) _____
- II If condition is due to pregnancy, what is the estimated date of delivery? (MM/DD/YY) _____

3. Dates of Consultations

- (a) Date of first visit (MM/DD/YY) _____
- (b) Date of second visit (MM/DD/YY) _____
- (c) Frequency Weekly Monthly Other (specify) _____

4. Nature of Treatment (including surgery and medication prescribed, if any)

5. Progress

- (a) Has patient ... Recovered? Improved? Unchanged? Retrogressed?
- (b) Is patient Ambulatory? House confined?
 Bed confined? Hospital confined?
- (c) If patient has been hospital confined, give name and address of hospital?
 Hospitalized from (MM/DD/YY) _____ Name and address of hospital _____
 To (MM/DD/YY) _____

6. Cardiac (if applicable)

- (a) Functional capacity Category 1 (no limitation) Category 2 (slight limitation)
 Category 3 (marked limitation) Category 4 (complete limitation)
- (b) Blood pressure (last visit) _____

Continued on next page

ATTENDING PHYSICIAN'S STATEMENT (cont'd)

7. Physical Impairment

- Class 1 - No limitation of functional capacity - capable of heavy work - no restrictions (0-10%)
- Class 2 - Medium manual activity (15-30%)
- Class 3 - Slight limitation of functional capacity - capable of light work (35-55%)
- Class 4 - Moderate limitation of functional capacity - capable of clerical/administrative (sedentary) activity (60-70%)
- Class 5 - Severe limitation of functional capacity - incapable of minimal (sedentary) activity (75-100%)

Limitations? (bending, lifting, etc.) _____

8. Mental / Nervous Impairment (if applicable)

What are your patient's limitations in relation to stress and interpersonal relations on the workplace?

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations with slight limitations.
- Class 3 - Patient is able to function in only limited stress situations and engage in interpersonal relations with moderate limitations.
- Class 4 - Patient is unable to function in stress situations or engage in interpersonal relations with marked limitations.
- Class 5 - Patient has significant psychological and social adjustment difficulties with severe limitations.

Remarks: _____

9. Prognosis

To the best of your knowledge, what is the period during which:

From To

(a) the patient has been TOTALLY DISABLED (unable to do any work)? (MM/DD/YY) _____

(b) the patient was or will be PARTIALLY DISABLED (able to work part-time)? (MM/DD/YY) _____

Anticipated date on which the patient should be able to return to work full-time? (MM/DD/YY) _____

10. Rehabilitation

Do you think your patient is able to participate in a vocational rehabilitation program? Yes No

11. Remarks

Attending Physician's Name (*print*) _____ Specialty _____

Address: _____

Telephone Number: _____ Signature: _____ Date: _____

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