COMBINED INSURANCE

P.O. Box 3720 MIP Markham, Ontario L3R 0X5

Claim No. ______

Please retain a copy of your completed claim form

CLAIMANT'S STATEMENT

(Please print)

Last Name	Given Name(s)	Telephone

Number	Street	Apt.

City	Province	Postal Code

Please describe any complications of your injury or illness since the last report

____

____

Medical Treatments received since the last report

____

____

Attending physicians' names and addresses

____

____

Hospitalization Dates (MM/DD/YY) (confirmation from hospital required)	Hospitals' Names and Addresses
From ________ To ________	

DISABILITY

	From	To
You were unable to perform any of the duties of your usual occupation (TOTAL DISABILITY) : (MM/DD/YY)	________	________
You were able to perform part of the duties of your usual occupation (PARTIAL DISABILITY): (MM/DD/YY)	________	________

Describe your present activities:

____

	Full Time	Part Time
Is there an anticipated date of return to work? (MM/DD/YY)	________	________

OTHER BENEFITS

	Yes	No	
Are you receiving disability benefits from the WSIB?	☐	☐	$________ /week (month)
Are you receiving disability benefits from the Employment Insurance?	☐	☐	$________ /week (month)
Are you receiving other disability benefits?	☐	☐	$________ /week (month)

Source:____

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 ______________________

SUPPLEMENTARY ATTENDING PHYSICIAN'S STATEMENT

(Please print)

1. Patient's Name

2. Diagnosis

   Primary Diagnosis________________________________

   Secondary Diagnosis________________________________

3. Describe any complications or other conditions contributing to prolonged disability

   ____

   ____

4. Date of last attendance (MM/DD/YY)________________

   Is this patient under your active care? ☐ Yes ☐ No

   If not, please explain:

   ____

   ____

5. Current treatment:

   ____

   ____

6. Patient's progress:

   ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

7. Disability

   What is your patient current status?

   To the best of my knowledge, the patient is still TOTALLY DISABLED (unable to do any work) ☐

   The anticipated date of return to work is: (MM/DD/YY) ________________

   The patient returned to work on: (MM/DD/YY) ________________

8. Rehabilitation

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

9. Remarks

   ____

   ____

   ____

Attending Physician's Name (please print)________________ Specialty________________

Complete Address:________________________________

Telephone Number:________________ Signature________________ Date________________

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

DATE________________ CLAIMANT'S SIGNATURE ________________

294132 (Rev. 09/2008)