

PLEASE COMPLETE AND RETURN ON / À COMPLÉTER ET
RETOURNER VERS LE _____

Claim # / Réclamation # _____

CLAIMANT'S STATEMENT / SOUMISSION DU RÉCLAMANT

| Name/Nom | Telephone Number / Numéro de téléphone | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--------------------------|--------------------------|--------------------------|--|--|-----|-----|-----|-----|-----|-----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Address/Adresse | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please describe any complications of injury or illness since last report / Décrivez toute complication de blessure ou maladie depuis le dernier rapport | | | | | | | | | | | | | | | | | | | | | | | | | |
| List medical treatments received since last report / Liste des traitements médicaux depuis le dernier rapport | | | | | | | | | | | | | | | | | | | | | | | | | |
| Doctor's name and address / Nom et adresse du médecin | <table style="width:100%; border-collapse: collapse;"> <tr> <th colspan="6">Treatment dates / dates des traitements</th> </tr> <tr> <th>Y/A</th> <th>M/M</th> <th>D/J</th> <th>Y/A</th> <th>M/M</th> <th>D/J</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> | Treatment dates / dates des traitements | | | | | | Y/A | M/M | D/J | Y/A | M/M | D/J | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Treatment dates / dates des traitements | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y/A | M/M | D/J | Y/A | M/M | D/J | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| Hospital where confined since last report / Hôpital où vous avez été confiné depuis le dernier rapport | <table style="width:100%; border-collapse: collapse;"> <tr> <th colspan="6">Date of hospitalization / Date d'hospitalisation</th> </tr> <tr> <th>Y/A</th> <th>M/M</th> <th>D/J</th> <th>Y/A</th> <th>M/M</th> <th>D/J</th> </tr> <tr> <td colspan="3">From / Du:</td> <td colspan="3">To / Au:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> | Date of hospitalization / Date d'hospitalisation | | | | | | Y/A | M/M | D/J | Y/A | M/M | D/J | From / Du: | | | To / Au: | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of hospitalization / Date d'hospitalisation | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y/A | M/M | D/J | Y/A | M/M | D/J | | | | | | | | | | | | | | | | | | | | |
| From / Du: | | | To / Au: | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| Have you been totally disabled to this date? / Avez-vous été totalement invalide jusqu'à maintenant? | <input type="checkbox"/> Yes/Oui <input type="checkbox"/> No/Non Y/A M/M D/J | | | | | | | | | | | | | | | | | | | | | | | | |
| When did you resume part of your duties? / Quand avez-vous pu reprendre une partie de votre travail? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| When did you resume all of your duties? / Quand avez-vous pu reprendre tout votre travail? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| When do you expect to resume part of your duties? / Quand pensez-vous reprendre une partie de votre travail? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| When do you expect to resume all of your duties? / Quand pensez-vous reprendre tout votre travail? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |

MY CLAIM IS ON THE FOLLOWING BASIS / MA RÉCLAMATION EST SUR LA BASE SUIVANTE

| Dates during which I was unable to perform all the duties pertaining to my usual occupation / J'ai été incapable d'accomplir toutes les tâches relatives à mon occupation habituelle | First day of total disability / Premier jour d'incapacité totale Last day of total disability / Dernier jour d'incapacité totale | <table style="width:100%; border-collapse: collapse;"> <tr> <th>Y/A</th> <th>M/M</th> <th>D/J</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> | Y/A | M/M | D/J | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|---|---|-----|-----|-----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Y/A | M/M | D/J | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| Dates during which I was able to perform part of the duties pertaining to my usual occupation / J'ai été capable d'accomplir certaines tâches relatives à mon occupation habituelle | First day of partial disability / Premier jour d'incapacité partielle Last day of partial disability / Dernier jour d'incapacité partielle | <table style="width:100%; border-collapse: collapse;"> <tr> <th>Y/A</th> <th>M/M</th> <th>D/J</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> | Y/A | M/M | D/J | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Y/A | M/M | D/J | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |

EMPLOYER'S STATEMENT / DÉCLARATION DE L'EMPLOYEUR

| | | | | | |
|--|--------------------------|--------------------------|--------------------------|----------|--|
| First day of absence from work / Première journée d'absence au travail | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Return to work / Retour au travail | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Partially disabled / Incapacité partielle | From / Du: | <input type="checkbox"/> | <input type="checkbox"/> | To / Au: | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Name of Employer / Nom de l'employeur | | | | | Y/A M/M D/J |
| Signature | Title / Titre | Signed on / Signé le | | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

AUTHORIZATION TO RELEASE INFORMATION / AUTORISATION

I HEREBY AUTHORIZE any hospital or physician who has attended me to disclose, when requested to do so by the Combined Insurance Company of America, any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

J'AUTORISE PAR LA PRÉSENTE tout hôpital, médecin ou tout autre personne qui m'ont traité ou examiné à donner sur demande à la Compagnie d'Assurance Combined d'Amérique, tout renseignement relatif à cette maladie ou blessure ou historique médical, consultations, prescriptions ou traitements et de fournir des copies de tous les rapports de médecins et d'hôpitaux. Une copie photographiée de cette autorisation sera considérée aussi valide que l'originale.

| | | | | | | | |
|-----------|--|--|--|----------------------|--------------------------|--------------------------|--------------------------|
| Signature | | | | Signed on / Signé le | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|-----------|--|--|--|----------------------|--------------------------|--------------------------|--------------------------|

IMPORTANT: A FORM NOT FULLY COMPLETED WILL DELAY SETTLEMENT OF YOUR CLAIM. / UNE FORMULE NON COMPLÉTÉE RISQUE DE RETARDER LE RÈGLEMENT.

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT / DÉCLARATION COMPLÉMENTAIRE DU MÉDECIN TRAITANT

Please return completed form to your patient / Veuillez compléter et retourner à votre patient(e)

| | |
|---|-------------------------------------|
| 1. Patient's Name / <i>Nom du patient:</i> | |
| 2. Diagnosis of present condition / <i>Diagnostic de l'invalidité actuelle</i> a) Primary / <i>Principale</i> b) Secondary (if applicable) / <i>Secondaire (le cas échéant)</i> | |
| 3. Indicate complications or new independent conditions, such as surgery, which may prolong the disability. <i>Veillez indiquer complications ou autres facteurs, telle une intervention chirurgicale, qui peuvent prolonger l'invalidité</i> | |
| 4. Date of latest attendance / <i>Date de la dernière visite</i> <div style="text-align: right; margin-right: 50px;">Y/A M/M D/J</div> <div style="text-align: right; margin-right: 50px;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <p style="text-align: center;">.....</p> | |
| 5. a) Have you been actively supervising this patient's care? / <i>Le patient a-t-il été constamment sous vos soins?</i> <input type="checkbox"/> No / <i>Non</i> If NO, comment in REMARKS / <i>Si NON, veuillez préciser sous REMARQUES</i> <input type="checkbox"/> Yes / <i>Oui</i> If YES, state frequency of visits / <i>Si OUI, veuillez indiquer la fréquence des visites</i> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"><input type="checkbox"/> Weekly / <i>Hebdomadaires</i></div> <div style="text-align: center;"><input type="checkbox"/> Other (specify) / <i>Autre (fréquence)</i></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"><input type="checkbox"/> Monthly / <i>Mensuelles</i></div> </div> | |
| b) Is patient following recommended treatment program? / <i>Le patient suit-il les traitements recommandés?</i> <input type="checkbox"/> No / <i>Non</i> If NO, comment in REMARKS / <i>Si NON, veuillez préciser sous REMARQUES</i> <input type="checkbox"/> Yes / <i>Oui</i> <div style="text-align: right; margin-right: 50px;">Y/A M/M D/J</div> <div style="text-align: right; margin-right: 50px;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> | |
| c) Date of latest treatment / <i>Date du dernier traitement</i> <div style="text-align: right; margin-right: 50px;">Y/A M/M D/J</div> <div style="text-align: right; margin-right: 50px;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> | |
| 6. To the best of your knowledge, is the patient totally disabled (unable to work/perform usual activities)? / <i>À votre connaissance, le patient est-t-il totalement invalide (incapable de travailler/vaquer à ses occupations quotidiennes)?</i> <input type="checkbox"/> No / <i>Non</i> If NO, on what date could the patient have returned to work? / <i>Si NON, à quelle date aurait-il pu reprendre le travail?</i> <input type="checkbox"/> Yes / <i>Oui</i> If YES, give approximate date when patient should be able to return to work. / <i>Si OUI, vers quelle date devrait-il pouvoir reprendre le travail?</i> <input type="checkbox"/> Indefinite / <i>Indéterminé</i> If INDEFINITE, give the estimated number of additional weeks before such return. / <i>Si INDÉTERMINÉ, nombre de semaines additionnelles estimées nécessaires avant la reprise du travail.</i> <div style="text-align: right; margin-right: 50px;">Additional Weeks / <i>Semaines Additionnelles</i></div> <div style="text-align: right; margin-right: 50px;"><input style="width: 100px; height: 20px;" type="text"/></div> | |
| 7. How long was or will patient be partially disabled (able to work part-time at own occupation)? / <i>Quelle a été ou sera la durée de l'invalidité partielle du patient (capacité de reprendre à temps partiel l'exercice de sa profession/activités quotidiennes)?</i> <div style="display: flex; justify-content: flex-end; margin-right: 50px;"> Y/A M/M D/J From / <i>Du:</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> To / <i>Au:</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> | |
| 8. Is patient a suitable candidate for a rehabilitation program? / <i>Le patient peut-il suivre un programme de ré-adaptation?</i> <div style="display: flex; justify-content: flex-end; margin-right: 50px;"> <input type="checkbox"/> No / <i>Non</i> <input type="checkbox"/> Yes / <i>Oui</i> </div> | |
| REMARKS / REMARQUES | |
| | |
| Physician's Name (please print) / <i>Nom du médecin (en lettres moulées)</i> | Telephone Number / <i>Téléphone</i> |
| Address / <i>Adresse</i> | Postal Code / <i>Code Postal</i> |
| Y/A M/M D/J <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |

Physician's Signature / Signature du médecin

Date

**THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION.
IL INCOMBE AU PATIENT DE FAIRE REMPLIR CE FORMULAIRE, LES FRAIS ÉTANT À SA CHARGE.**