



PLEASE PRINT

POLICY NO.:

CLAIMANT'S STATEMENT

Surname: \_\_\_\_\_ Given Name \_\_\_\_\_

Address: (Street & No.) \_\_\_\_\_

Apt./Unit No.: \_\_\_\_\_ Telephone No.: ( ) \_\_\_\_\_

City/Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

1. Date of Accident: \_\_\_\_\_

2. Full details of accident and injury sustained: \_\_\_\_\_

3. Have you had a similar injury previously? Yes \_\_\_\_\_ No \_\_\_\_\_

Provide dates and details: \_\_\_\_\_

4. Name and Address of Physician: \_\_\_\_\_

5. Where and when did your Physician first attend you? \_\_\_\_\_

6. Names and Addresses of any other physicians who may have treated you as the result of this accident.

7. What other accident or health insurance do you have?

Company: \_\_\_\_\_ Indemnity: \_\_\_\_\_

8. Are you receiving a disability pension, W.S.I.B. or unemployment benefits? Yes ( ) No ( )

If "yes", for what? \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Date of First Payment: \_\_\_\_\_

9. (a) Are you/were you totally disabled? Yes ( ) No ( ) From \_\_\_\_\_ To \_\_\_\_\_

(b) Are you/were you house confined? Yes ( ) No ( ) From \_\_\_\_\_ To \_\_\_\_\_

(c) Are you/were you hospitalized? Yes ( ) No ( ) From \_\_\_\_\_ To \_\_\_\_\_

If "yes", name and address of Hospital \_\_\_\_\_

10. (a) When did you or will you resume work - PART TIME? Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

(b) When did you or will you resume work - FULL TIME? Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

I hereby certify that the above answers are both true and complete:

Date: \_\_\_\_\_ Claimant sign here: \_\_\_\_\_

AUTHORIZATION TO RELEASE

**PERSONAL INFORMATION NOTICE:** I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by American Home Assurance Company, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. **CERTIFICATION:** The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim. **AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with American Home Assurance Company, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Dated: \_\_\_\_\_ Claimant sign here: \_\_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT**

<b>Physician's Name (Print)</b> Name: _____ Street: _____ City: _____ Prov. _____ Postal Code: _____	<b>Patient's Name (Print)</b> Name: _____ Street: _____ City: _____ Prov. _____ Postal Code: _____																		
Diagnosis including complications (if fracture, specify bone and type of fracture) and Nature of Injury:																			
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="width:10%;">DATE OF</td> <td style="width:10%;">First Attendance</td> <td style="width:5%;">D</td> <td style="width:5%;">M</td> <td style="width:5%;">Y</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;">Actual Loss</td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table>		DATE OF	First Attendance	D	M	Y									Actual Loss			
	DATE OF	First Attendance	D	M	Y														
		Actual Loss																	
Please outline the treatment plan recommended and prescribed: _____ _____ _____																			
Date of next scheduled follow up appointment: _____																			
Is your patient totally disabled and unable to perform their occupational responsibilities? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
Please provide the term of total disability: From: _____ To: _____																			
Please provide the expected return to work date: _____																			
Was claimant hospitalized? ( ) No, and if ( ) Yes - Give hospital name, address and date admitted.																			
Names and addresses of other physicians or surgeons, if any, who attended claimant																			
I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.																			
DATE: _____	SIGNATURE: _____ M.D.																		
ADDRESS: _____																			

**EMPLOYER'S STATEMENT**

Name of Employee: _____	Date of Employment: _____
Name of Employer: _____	
Address of Employer: _____	
Did the injury occur while claimant was performing the regular and assigned duties of their occupation?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did the injury occur while claimant was travelling directly to or from their regular place of employment?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
Description of Injury: _____	
Employee was: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Commissioned <input type="checkbox"/> Other(explain) _____	
Weekly Salary: _____	Occupation/Job Title: _____
Date Last Worked: _____	
Will or is this employee receiving any source of income replacement during his/her term of disability (i.e. W.S.I.B, short/long term disability benefits). If yes; please advise source and amount being paid:	
_____	
Date : _____	Signature: _____
Telephone No.: _____	Title: _____