



ACCIDENT INSURANCE CLAIM FORM

Chubb Life Insurance Company of Canada
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Toronto, Ontario M5L 1E2
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Please follow these instructions:

- 1. PART A - This section must be completed, in full and signed by the insured. If insured is under age 18, this section must be completed by the Parent or Guardian. If claim is for Accident Expense Reimbursement and/or fracture benefit, enclose original expenses and have PART B - Physician's Statement completed.
2. PART B - This section is to be completed and signed by physician (any costs incurred for the completion of this form are the insured's responsibility. When applicable, may differ per policy).
3. PART C - This section is to be completed by your dentist if your claim is for dental accident expenses.

Please ensure that original claim documents and invoices are submitted

PART A - CLAIMANT STATEMENT

Form with fields for Policy No., Name of Insured (Last/First Name), Address (City/Province/Postal Code/Phone #), Date of Accident (Month/Day/Year/Time), Date of Birth, Place of Accident, Injury description, and Insurance coverage status.

Claimant's Certification: The above statements 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 without refund of any premiums paid.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance Company of Canada, 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.

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, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

Insured/Insured's Parent/Guardian Signature

Date (DD/MM/YYYY)

PART B – ATTENDING PHYSICIAN'S STATEMENT

The patient is financially responsible for the completion of the form.

| | | | |
|--|--|--|--------------|
| Physician's Name (Print) | | Patient's Name (Print) | |
| Name: | | Name: | |
| Address: | | Address: | |
| City: | | City: | |
| Province: | Postal Code: | Province: | Postal Code: |
| Phone #: () | | Phone #: () | |
| Diagnosis including complications (If fracture, specify bone and type of fracture, provide x-ray report) and Nature of Injury: | | | |
| | | | |
| Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| a. | Symptoms first appeared or accident happened (mm/dd/yy): | | |
| | b. | Patient has had same or similar condition: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when and describe: | |
| | | | |
| | | | |
| Was claimant hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide the following information: | | | |
| Name of Hospital: | | Date Admitted (DD/MM/YYYY): | |
| Hospital Address: | | | |
| City: | Province: | Postal Code: | |
| Date of First Visit for present period of disability (DD/MM/YYYY): | | | |
| Date of last attendance (DD/MM/YYYY): | | | |
| Date of next scheduled follow up appointment (DD/MM/YYYY): | | | |
| Please outline the treatment plan recommended and prescribed: | | | |
| | | | |
| | | | |
| 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.

M.D.

Signature Date (DD/MM/YYYY)

| | | |
|-------------------|-----------|--------------|
| Address: | | |
| City: | Province: | Postal Code: |
| Phone #: () | | |

PART C – ATTENDING DENTIST’S STATEMENT

Please provide the following documentation: Standard Dental claim form for dental services provided, including the dates of service, tooth and procedure codes and fees incurred OR dental estimate.

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| Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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This is an accurate statement of services performed, and fees charged.

For dentist’s use only, for additional information re: Diagnosis, procedures or complications and special considerations:

| | |
|---------------------|-------------------|
| Dentist’s Signature | Date (DD/MM/YYYY) |
|---------------------|-------------------|

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of my treatment. I authorize release of the information contained in this claim form to my insuring company or its agents. I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

| | |
|---|-------------------|
| Insured/Insured’s Parent/Guardian Signature | Date (DD/MM/YYYY) |
|---|-------------------|

