Severe Loss of Autonomy - Claimant's Statement

Important: Fill out in block letters and answer each section as accurately as possible.

Section A – Collection, Use and Disclosure of Personal Information

The personal information we collect in this form allows UV Insurance to obtain information about your loss of autonomy, including through access to information relative to your health.

The personal information is used to:

- Identify the individual
- Establish and update information and the needs of the individual, as appropriate
- Comply with legal and regulatory requirements, including tax rules and the prevention, detection and enforcement of offences, cyber threats and fraud

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing, as well as to any other person authorized by law.

Section B – Statement

1. Contract # _____

2. Insured's first name _____ Last name _____

3. Date of birth Y M D **4.** RAMQ # _____

5. Address _____

City _____ Province _____ Country _____ Postal code _____

6. Phone _____-_____ **7.** Phone (work) _____-_____ Ext. _____

8. Occupation _____ Date of last day worked Y M D

9. Type or nature of illness _____

a) Date when symptoms began Y M D

b) Date of diagnosis Y M D

c) Date when you were informed of the diagnosis Y M D

10. Please provide full details on the origin and type of disease you are currently suffering from:

11. Date of your first medical consultation for this illness Y M D

12. Please provide the name and address of the physician consulted:

First name _____ Last name _____

Address _____

City _____ Province _____ Postal code _____

13. Are they your usual attending physician? ☐ Yes ☐ No

If **No**, who referred you to this physician? _____

14. Please enter your family physician's name, address and telephone number:

First name _____ Last name _____

Address _____

City _____ Province _____ Postal code _____

Phone _____-_____

15. Date of your first treatments for this illness Y M D

Section B – Statement (cont.)

16. Have you ever suffered from or received treatment for a related illness? ☐ Yes ☐ No

If **Yes**, please provide all the details and dates.

Details	Date
	Y M D
	Y M D
	Y M D
	Y M D

17. Please tell us what treatments you are currently receiving, including the details and dates of any screening or examination in hospital or at a clinic, and any treatments received:

18. Have any of your family members ever suffered from a related illness? ☐ Yes ☐ No

If **Yes**, please specify what your relationship is with that person, the type of disease they are suffering from and the age at which the disease was diagnosed:

Relationship	Type of disease	Age at which the disease was diagnosed

19. Please provide the names, addresses and telephone numbers of all physicians who treated you or the hospitals where you were treated for this illness (include the dates and reasons for your visits).

Section C – Consent and Signature

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing your claim, as well as to any other person authorized by law.

By signing this document, you authorize any individual or legal entity or any public or parapublic body that possesses personal information about you concerning, among other things, your state of health, medical history or eligibility for benefits, including but not limited to any physician, dentist, or other practitioner, hospital, medical or paramedical clinic, SAAQ, RAMQ and WCB to disclose this information to UV Insurance or its reinsurers upon request.

If any of your personal information is inaccurate, incomplete or unclear, you may have it corrected by submitting a request to UV Insurance.

You also have the right to request information about how your personal information is used.

For more details, please visit our website and see our **Privacy Policy.**

I acknowledge that a photocopy of this consent, which is valid for the duration of this claim, has the same value as the original.
I understand that the completed form does not constitute the approval of my claim by the Company.

The undersigned confirms that they have reviewed the above information and agrees to the collection, use and disclosure of the personal information contained herein. This consent also applies to the collection, use and disclosure of the beneficiaries' personal information, and the undersigned confirms that prior consent has been obtained from such beneficiaries.

X _____ _____ Date Y M D

Insured's signature | Signatory's name in block letters

Send the form to the following email address: ind.client@uvinsurance.ca
P.O. Box 696, Drummondville (Quebec) J2B 6W9 ■ Phone: 819 478-1315 ■ Toll-free: 1 800 567-0988 ■ Fax: 819 474-1990