Claim for benefits - Accident insurance

Accidental loss of limbs, loss of vision or paralysis due to an accident

EQC029

Attending Physician's Statement

Important: Fill out in block letters and answer each section as accurately as possible. Any fees that may be charged for completing this form are the responsibility of the person concerned.

Section A — Collection, Use, and Disclosure of Personal Information

The personal information we collect in this form allows UV Insurance to process a claim for accident insurance benefits by collecting information from the attending physician.

Your personal information is used to:

- Identify the individual;
- Initiate or continue a claims process;
- Comply with legal and regulatory requirements (in particular to prevent, detect or prosecute offences, cyber threats and fraud)

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

Section B – Identification of the Injured Person

1. First name _____ Last name _____
2. Date of birth Y M D

Section C – Declaration

1. Date of the accident Y M D
2. What type of accident was it? ☐ Work ☐ Sports ☐ Motor vehicle ☐ Other _____
3. At the time of the accident, was the person under the influence of drugs or alcohol, or had they taken an overdose of hallucinogens, drugs not properly prescribed by a doctor, poison, gas, or gasoline? ☐ Yes ☐ No
   If **Yes**, please provide details and test results _____
4. Description of the loss _____
5. Is the loss a direct and sole result of the injuries sustained in the accident? ☐ Yes ☐ No
6. What is the level of amputation or the % of loss of use _____ Date Y M D
7. Is the loss of use complete and irreversible? ☐ Yes ☐ No If **Yes**, since when? Y M D

Loss	Left	Right
☐ Eye	☐ Yes ☐ No	☐ Yes ☐ No
☐ Hand	☐ Yes ☐ No	☐ Yes ☐ No

Loss	Left	Right
☐ Foot	☐ Yes ☐ No	☐ Yes ☐ No
☐ Other _____	☐ Yes ☐ No	☐ Yes ☐ No

☐ Vision loss

8. At the last exam Y M D

	Left	Right
Visual acuity without corrective lenses		
Visual acuity with corrective lenses		
Vision can be partially or completely corrected by	☐ Corrective lenses ☐ Treatments ☐ Operation ☐ No means of correction	☐ Corrective lenses ☐ Treatments ☐ Operation ☐ No means of correction

9. Is the loss of use a direct result of the accident and independent of any other cause? ☐ Yes ☐ No
   If **No**, please provide details: _____

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Section C – Declaration (cont.)

☐ Paralysis

10. Did the accident result in any of the following conditions? ☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia
11. When did the paralysis begin? _____
12. Is the accident the only cause of the paralysis? ☐ No ☐ Yes
13. If the paralysis is not the result of an accident, what are the pre-existing medical conditions that led to paralysis?

_____

14. Is the paralysis permanent, total and irreversible? ☐ No ☐ Yes

Section D – Physician Identification

1.

Other attending physicians (first name, last name)	Name of hospital or medical centre	Date
		Y M D
		Y M D
		Y M D

2. Additional comments

Section E – Consent and Signature

By signing, you understand that if any of your personal information is inaccurate, incomplete or ambiguous, you may request a correction by submitting a request to UV Insurance. You also have the right to request information about how your personal information is used.

In addition, you may withdraw your consent to the disclosure or use of your personal information at any time by making a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

For further details, please visit our website and consult our **Privacy Policy.**

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

Signature

X _____ _____ Date Y M D

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

Specialty _____ Licence # _____

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Claimant's Statement

Important: Fill out in block letters and answer each section as accurately as possible. This application must be completed by the insured person if they are 14 years of age or older. If the insured person is unable to do so or is under the age of 14, the insured person's parent, guardian or legal representative may complete the application.

Section A — Collection, Use, and Disclosure of Personal Information

The personal information we collect in this form allows UV Insurance to process a claim for accident insurance benefits.

Your personal information is used to:

- Identify the individual;
- Initiate or continue a claims process;
- Comply with legal and regulatory requirements (in particular to prevent, detect or prosecute offences, cyber threats and fraud)

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

Section B – Identification of the Insured

1. Contract # _____
2. First name _____ Last name _____
3. Date of birth Y M D ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **4.** Sex at birth ☐ Female ☐ Male
4. Phone (work) ☐ ☐ ☐ - ☐ ☐ ☐ ☐ Ext. _____ Phone (home) ☐ ☐ ☐ - ☐ ☐ ☐ ☐

Section C – Declaration

1. Date of the accident Y M D ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **2.** Time of the accident _____ ☐ AM ☐ PM
3. Location of the accident _____
4. Description of the circumstances of the accident

   _____
5. What type of accident was it? ☐ Work ☐ Sports ☐ Motor vehicle ☐ Other _____
6. What is the nature of the injuries? _____
7. Please name the physicians who treated the insured person

Attending physicians (first name, last name)	Name of hospital or medical centre

8. Has the patient undergone surgery? ☐ Yes ☐ No
   If **Yes**, what is the nature of the procedure? _____ Date Y M D ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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Section D – Consent and Signature

UV Insurance collects personal and medical information from a variety of sources (medical examinations, physicians, hospitals, information agencies, etc.) to assess your insurability, manage claims and maintain records. This information may be shared, where necessary, with third parties such as MIB LLC, an organization that centralizes data for member insurers, as well as with reinsurers and other authorized institutions. The information remains confidential and is only accessible to authorized employees. If any of th personal information above is inaccurate, incomplete or unclear, you have the right to request to have it corrected by contacting our customer service department.

By signing, you understand that if any of your personal information is inaccurate, incomplete or ambiguous, you may request a correction by submitting a request to UV Insurance. You also have the right to request information about how your personal information is used.

In addition, you may withdraw your consent to the disclosure or use of your personal information at any time by making a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

For further details, please visit our website and consult our **Privacy Policy.**

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

I also authorize any healthcare professional, healthcare provider, public or private health or social service institution, insurer or reinsurer, MIB LLC., any investigative agency and any individual or legal entity likely to hold personal information related to my health condition, medical history or lifestyle that is necessary for the reasons stated in the Notice of File Creation to share such information with UV Insurance and its reinsurers. This authorization is only valid for the period required to achieve the purposes for which it was requested.

Signature

X _____ _____ Date Y M D

Signature of the insured person (if 14 years of age or older) | Signatory's name in block letters

If the claimant is different from the insured person

1. Claimant name _____ Relationship to the insured person _____
2. Address _____

City _____ Province _____ Country _____ Postal code _____

X _____ _____ Date Y M D

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

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