

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 begin the process of analyzing your critical illness claim.

The personal information collected 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 the application, as well as to any other person authorized by law.

Section B – Identification

1. First name _____ Last name _____
2. Certificate no. _____ Group no. _____ Billing unit _____ Class _____
3. Date of birth _____ 4. Provincial health insurance number _____
5. Address _____
City _____ Province _____ Country _____ Postal code _____
6. Telephone (home) _____ Telephone (work) _____ Extension _____
7. Occupation _____
8. Date of last day worked (if applicable) _____

Section C – Claim Information and Other Related Information

1. Date of onset of symptoms _____
2. Date of your first medical consultation for this illness _____
3. Date of diagnosis _____
4. What is the name and institution of the physician you consulted?
Physician _____ Institution _____
5. Are they your usual attending physician? ☐ Yes ☐ No
If **No**, who referred you to this physician? _____
Date of your first treatments for this illness _____
6. Have you ever suffered and/or received treatment for a related illness? ☐ Yes ☐ No
If **Yes**, please provide us with all the details and dates.

Section C – Claim Information and Other Related Information (cont.)

7. 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.

--

8. Please provide the names, institutions and telephone numbers of all physicians who treated you or the hospitals where you were treated for this illness (include the date and reason for your visits).

Prescribing physician	Institution	Phone number
		____-____-____ Ext.: ____
Date	Reason for visit	
____-____-____		

Prescribing physician	Institution	Phone number
		____-____-____ Ext.: ____
Date	Reason for visit	
____-____-____		

Prescribing physician	Institution	Phone number
		____-____-____ Ext.: ____
Date	Reason for visit	
____-____-____		

Prescribing physician	Institution	Phone number
		____-____-____ Ext.: ____
Date	Reason for visit	
____-____-____		

Prescribing physician	Institution	Phone number
		____-____-____ Ext.: ____
Date	Reason for visit	
____-____-____		

Prescribing physician	Institution	Phone number
		____-____-____ Ext.: ____
Date	Reason for visit	
____-____-____		

9. If not already mentioned in the questionnaire, please provide your family physician's name, institution, and telephone number.

First name _____ Last name _____

Institution _____ Telephone ____-____-____ Extension _____

Section D – Consent and Signature

For the purposes of administering my file and assessing claims, I authorize any individual or legal entity or any public or parapublic body that possesses personal information about me concerning, among other things, my 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, to disclose this information to UV Insurance or its reinsurers upon request.

Similarly, I authorize UV Insurance to disclose such information to said third parties and to its reinsurers. For the same purpose and to collect the same type of information, I also consent to UV Insurance or its reinsurers requesting an investigation report about me.

I understand that the completed form does not constitute the approval of my claim by UV Insurance.

By signing, you understand that in the event 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 more details, please visit our website and see 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

By signing below, the undersigned certifies that the information provided is complete and true and that a photocopy of this document is of the same value as the original.

X _____ Date _____
Insured's signature Name of signatory (please print)

