UV INSURANCE

INDIVIDUAL INSURANCE

**Disability Insurance Claim/Extension**

ITP Version

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

## Section A—Collection, Use and Communication of Your Personal Information

Through this form, UV Insurance collects your personal information in order to review the disability insurance claim.

Your personal information may also be used specifically to:

- Confirm your identity;
- Establish and update the profile, needs, and objectives;
- Comply with legal and regulatory requirements (e.g., to prevent, detect or suppress offences, cyber threats, and fraud).

The information disclosed in this form will be shared with UV Insurance personnel responsible for processing your request for reduced paid-up insurance under the above-mentioned contract, as well as with any other person authorized by law.

## Section B—Claim for Benefits

**1.** Contract # _____ **2.** Occupation prior to disability _____

**3.** First name _____ Last name _____

**4.** Date of birth Y M D

**5.** Address _____

City _____ Province _____ Country _____ Postal code _____

**6.** Telephone ___ ___ - ____

**7.** Cause of disability _____

**8.** Have you worked since the onset of your disability or your last application for an extension? ☐ Yes ☐ No

If **Yes**, on what date? Y M D

**9.** Has there been an improvement in your health over the past two years? ☐ Yes ☐ No

If **Yes**, please specify: _____

**10.** Description of your daily activities while disabled:

_____

**11.** Names and addresses of recently consulted physicians, including the date of each consultation and the frequency of follow-ups:

| Physician's first and last name | Hospital | Date | Frequency of follow-ups |
|---|---|---|---|
| | | Y M D | |
| | | Y M D | |
| | | Y M D | |

**12.** Has there been a change in your medication? ☐ Yes ☐ No

If **Yes**, what is it? _____

**13.** Have you required medical care in the past two years? ☐ Yes ☐ No

If **Yes**, please specify: _____

## Section B—Claim for Benefits (cont.)

**14.** Are you still receiving benefits from:

| | Yes | No | Date of acceptance |
|---|---|---|---|
| the Canada Pension Plan (disability or retirement) | ☐ | ☐ | Y M D |
| the Quebec Pension Plan (disability or retirement) | ☐ | ☐ | Y M D |
| Employment and Immigration Canada (EIC) | ☐ | ☐ | Y M D |
| the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) | ☐ | ☐ | Y M D |
| the Société de l'assurance automobile du Québec (SAAQ) | ☐ | ☐ | Y M D |
| or any other organization or insurer | ☐ | ☐ | Y M D |

## Section C—Consent and Signature

UV Insurance collects personal and medical information from various sources (medical examinations, doctors, hospitals, credit bureaus, etc.) in order to assess your insurability, manage claims, and maintain its records. This information may be shared, when 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 accessible only to authorized employees.

By signing this form, the undersigned understands that if any of their personal information is inaccurate, incomplete, or ambiguous, they may request that it be corrected by submitting a request to UV Insurance.

The undersigned also has the right to request information about the use of their personal information. In addition, they may withdraw their consent to the disclosure or use of their personal information at any time by sending a request to the Privacy Officer at UV Insurance at the following address: 1990 Jean-Berchmans-Michaud street, Drummondville (Quebec) J2C 7G7.

For more information, please visit our website to view our **Privacy Policy.**

Furthermore, by signing below, the undersigned authorizes any employer, any healthcare professional or provider, any healthcare provider, any public or private healthcare or social services institution, any insurer or reinsurer, MIB LLC, any investigative agency, and any individual or entity that may hold personal information related to the undersigned's health status, medical history, or lifestyle habits—as necessary for the purposes stated in the notice of file creation—to disclose such information to UV Insurance or its reinsurers. This authorization is valid only for the period necessary to fulfill the purposes for which it was requested.

**X** _____ _____ Date Y M D

Signature of the contract owner | 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