UV INSURANCE

INDIVIDUAL INSURANCE

Travel Certificate for Receiving Medical Care

(For the first 15 days following the accident)

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

Through this form, UV Insurance collects your personal information in order to process your claim for travel related to an accident that occurred within the past 15 days.

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—Travel Details

1. First name ______________________ Last name ______________________

2. Address ______________________

City ______________________ Province __________ Postal code __________

3. Date of accident Y | M | D

4. Contract # ______________________

Travel dates	Mode of transportation	Amount claimed	Mileage (round trip)	Location	Reason
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		
Y M D		$	/KM		

Section C—Consent and signature

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.**

The information disclosed in this form will be shared with UV Insurance staff responsible for your request, as well as any other persons authorized by law.

X ______________________ ______________________ Date Y | M | D

Signature of the injured person or their representative — Full name of the injured person or their representative

For the use of UV Insurance: __________ KMS x __________ = __________

Envoyer le formulaire à l'adresse courriel suivante : ind.client@uvassurance.ca

C.P. 696, Drummondville (Québec) J2B 6W9 ▪ Téléphone : 819 478-1315 ▪ Sans frais : 1 800 567-0988 ▪ Télécopieur : 819 474-1990

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