UV INSURANCE

INDIVIDUAL INSURANCE

Claim - Accidental Fracture

EQC028

Attending Physician's Statement

Important: Please fill out in block letters and complete 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, from the attending physician, information about the accident suffered by the insured person. This includes accessing personal information related to the insured person's health status and medical history held by the attending physician, the medical facility where the records are kept or any government agency.

The 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 responsible for processing the application, as well as to any other person authorized by law.

Section B – Identification of the Injured Person

1. First name _____ Last name _____
2. Primary address _____

   City _____ Province _____ Country _____ Postal code _____
3. Date of birth Y M D

Note: Any fees that may be charged for completing this form are the responsibility of the person concerned.

Section C – Details of the Accident

1. Date of the accident Y M D
2. Date of the first consultation following the accident Y M D
3. Type of accident: ☐ Work-related ☐ Motor vehicle ☐ While playing sports
   ☐ Other (please specify) _____
4. Among the injuries sustained, were there one or more fractures, dislocations, or second- or third-degree burns? Please specify
5. Is there a bruise or wound visible on the surface of the body at the site of the fracture(s), dislocation(s), or second- or third-degree burn(s)?
6. Were the injuries sustained as a result of a fight or public altercation? ☐ Yes ☐ No
7. Did the accident result from the intentional or unintentional ingestion of drugs, toxic substances or toxic gases? ☐ Yes ☐ No
8. Was a blood sample taken to determine blood alcohol content? ☐ Yes ☐ No
   If **Yes**, enter the result _____
9. Has the patient been diagnosed with a disease or condition that causes bone weakening, such as osteoporosis or osteopenia?
   ☐ Yes ☐ No If **Yes**, please provide details, including dates.
10. Specify the nature of the surgical procedure(s), if applicable, and provide the dates of the procedure(s).

Important: Attach a copy of the medical imaging report.

Section D – Consent and Signature

Note that if any of the personal information provided herein is inaccurate, incomplete or ambiguous, the insured may request a correction by submitting a request to UV Insurance.

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

As the attending physician, I declare that I am acting in accordance with privacy laws and regulations.

By signing at the bottom of this form, I confirm that the information provided is accurate.

Physician's signature

1. First name _____ Last name _____

2. Primary address _____

City _____ Province _____ Country _____ Postal code _____

3. Specialty _____ **4.** Licence number _____

X _____ _____ Date Y M D

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