

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

Section A – Collection, Use and Disclosure of Personal Information

With this form, the collection of personal information allows UV Insurance to collect your personal information related to your disability situation to continue the debt insurance claim process.

The personal information collected is used to:

- ▶ Identify the individual
- ▶ Start or continue a disability claim process
- ▶ 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, as well as to any other person authorized by law.

Section B – Claimant Identification

1. Contract# _____
2. First name _____ Last name _____
3. Date of birth

Y	M	D
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 4. Phone

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 5. RAMQ # _____
6. Email _____
7. Address _____
City _____ Province _____ Country _____ Postal code _____

Section C – Disability Information

1. Date of onset of the disability

Y	M	D
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2. Reason for the disability _____
3. Is the disability caused by an accident? ☐ Yes ☐ No (skip to question 7) If **Yes**, date of the accident

Y	M	D
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4. Where did the accident occur? _____
5. At what time did the accident occur? _____ ☐ AM ☐ PM
6. Please describe the circumstances of the accident in detail:
7. Were you hit by an external source? ☐ Yes ☐ No
8. Is the disability due to an illness? ☐ Yes ☐ No
If **Yes**, on what date did the first symptoms appear?

Y	M	D
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9. Date of first medical consultation

Y	M	D
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 Location _____
10. Attending physician _____ Family physician _____
11. Specify the injuries and symptoms for this disability:
12. Tests conducted _____
13. Current treatments _____
14. Have you been hospitalized? ☐ Yes ☐ No
If **Yes**, from

Y	M	D
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 to

Y	M	D
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Hospital's name _____ Address _____

Section C – Disability Information (cont.)

15. Please provide the names of the physicians consulted in the last five years, including their specialty, address, and date and reason for the consultation:

Physician's name	Specialty	Clinic or hospital	Date	Reason
			Y M D	
			Y M D	
			Y M D	
			Y M D	
			Y M D	

16. Have you ever suffered from the same illness or a related illness or similar accident? ☐ Yes ☐ No

If **Yes**, date Y M D Reason Physician

Section D – Employment Information

- ☐ If you were working at the beginning of the disability, please answer the following questions:

- Job held at the time of disability
- Briefly describe your tasks, including percentages for manual, administrative, and other tasks
- Employer's name
- Address (number, street) Office
City Province Postal code
- Are you still employed there? ☐ Yes ☐ No If **No**, since when? Y M D
- Date of last day worked Y M D
- If you worked part-time or were on light duty or temporary assignment before your full disability, please specify the periods:
☐ Part-time from Y M D to Y M D
☐ On light duty from Y M D to Y M D
☐ On temporary assignment from Y M D to Y M D
- Date of return to work Y M D

- ☐ If you were not working at the beginning of the disability, please answer the following question:

- How long have you been fully disabled? Y M D

Source of Income Statement:

- Do you receive disability benefits from another insurance company? ☐ Yes ☐ No
If **Yes**, please enter the name of the insurance company Since when? Y M D
Policy type Amount received
- Have you applied for or do you intend to apply for benefits from the following organizations?

Organizations	Date	Status*
☐ ESDC (employment insurance for illness)	Y M D	
☐ QPP/CPP	Y M D	
☐ CNESST/WSIB	Y M D	
☐ IVAC	Y M D	
☐ SAAQ	Y M D	
☐ Other:	Y M D	

*Status: accepted (1), refused (2), under consideration (3) or appealed (4).

Section E – Evidence Required

Proof of loans, issued by the financial institution, to be provided for a debt insurance claim:

- ☐ Copy of each contract or loan agreement or lines of credit (mortgage, personal, vehicle, student, commercial or financing)
- ☐ Copy of the account statement, including the balance of each loan or margin at the date of disability
- or**
- ☐ Copy of lease

Note: Please provide all the information required to assess your application to avoid additional delays in processing your file.

Section F – Consent and Signature

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.

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 _____ Signature _____ Signatory's name in block letters Date ____ / ____ / ____
Y M D

