

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

Section A—Member Identification

1. Contract number _____
2. First name _____ Surname _____

Section B—Questionnaire

1. On _____, I reported to The Union Life Mutual Insurance Company ("UV Insurance") that I suffered an injury, an illness, or another event causing or likely to cause inability to work and eligible for a claim to be submitted to the Commission des normes, de l'équité, de la santé et de la sécurité au travail (CNESST), the Société de l'assurance automobile du Québec (SAAQ), the Indemnisation des victimes d'actes criminels (IVAC) or to any other compensation provider applicable to my disability status, on or about the _____.
- Accordingly, I declare that from that date to the date of signing this statement of claim:
- a) I receive regular medical attention related to my Disability Status;
- b) I have not carried out any paid work; and
- c) I am not receiving any benefits related to my Disability Status.
2. ☐ On _____, I submitted a claim to the Commission des normes, de l'équité, de la santé et de la sécurité au travail (CNESST), the Société de l'assurance automobile du Québec (SAAQ), the Indemnisation des victimes d'actes criminels (IVAC) or any other compensation provider applicable related to my Disability Status, and this claim is currently under review.
- ☐ On _____, I agreed to submit, within 10 days of the date of this statement of claim, a claim to the third-party payer applicable to my Disability Status.
3. If I wish to withdraw my claim from the third-party payer and/or before accepting any settlement or mediation regarding my claim before receiving their first decision, I agree to consult UV Insurance in a timely manner and obtain written permission from UV Insurance before proceeding.
4. If I withdraw my claim from the third-party payer or agree to a settlement or mediation process in respect of it, before I have received their first decision and without UV Insurance's prior written consent, I undertake to promptly reimburse UV Insurance, for an amount equal to the sum of the gross disability benefits it has paid me as at that date, if any, and I agree that, as of that date, no benefits will be payable by UV Insurance related to my Disability Status, directly or indirectly, or in connection with any recurrence related to it.
5. If my claim submitted to the third-party payer is accepted, I undertake to reimburse UV Insurance for an amount equal to the gross amount of the disability benefits paid to me as at that date related to my Disability Status, if any, within ten (10) days of receipt of the first payment from the third-party payer.
6. In the event of my death, I hereby authorize UV Insurance to use the proceeds of my life insurance coverage to repay any amounts that may be due hereunder.
7. In consideration of the above, I acknowledge that UV Insurance agrees to pay me disability benefits related to my Disability Status in accordance with my insurance policy, but in consideration of these representations and undertakings and pending a final decision on my claim submitted to the third-party payer. I acknowledge that this is the case, as my insurance policy does not cover me in the event of a disability resulting from a work-related injury or illness.
8. Finally, I acknowledge that UV Insurance's payment of benefits related to my Disability Status pending the third-party payer's decision does not constitute, at any time or in any manner, a waiver by UV Insurance of any exception or exclusion under my insurance policy for both my current Disability Status and any future events.
9. Any debt incurred as a result of dual compensation, namely the receipt of disability benefits from UV Insurance and the third-party payer in respect of my Disability Status, will be considered fraudulent within the meaning of the applicable laws, and, thus, non-dischargeable in terms of bankruptcy.

Section C—Signatures

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

Y	M	D
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Insured's signature Signatory's name in block letters

X _____ Date

	Y		M		D
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Witness's signature Signatory's name in block letters

