CLAIM REQUEST – INDIVIDUAL INSURANCE
ACCIDENTAL FRACTURE

CLAIMANT'S STATEMENT

POLICY NO: ____________________

First and Last Name of the injured: ____

Address: ____

____________________________ Postal Code ______________

Date of Birth: ____

Home Telephone Number: ( ) ______________ Work Telephone Number: ( ) ______________

DETAILS REGARDING THE ACCIDENT

1. Date of the accident: ______________________________
2. Time of the accident: ______________________________
3. Location of the accident: ____
4. Type of accident:
   a) Work related accident: __________
   b) Motor vehicle accident: __________

      If yes, were you the driver or **passenger** of the **vehicle**? ______________________________
   c) Sport injury: __________

      Were you remunerated for your participation in this sport? __________
   d) Other, specify: ____
5. Please provide a complete description of the circumstances leading to the accident: ____

   ____

   ____

   ____
6. Were you alone or with others? ______________________________

   If with others, please provide the names, addresses and phone numbers of the others: ____

   ____________________________ Postal Code ______________

   ____

   ____________________________ Postal Code ______________
7. Had you consumed any alcoholic beverages before the accident? __________ **If yes**, how many? ______________

IF THE INJURIES OCCURRED AS A RESULT OF A MOTOR VEHICLE ACCIDENT AND YOU WERE THE DRIVER, PLEASE INCLUDE A COPY OF THE POLICE REPORT.

I DECLARE THAT ALL INFORMATION STATED ABOVE IS COMPLETE AND TRUE.

X ____ **X** ______________________________

POLICY OWNER SIGNATURE **DATE**

EQC028 (11-04)

UV INSURANCE

MEDICAL STATEMENT – INDIVIDUAL INSURANCE
ACCIDENTAL FRACTURE

ATTENDING PHYSICIAN STATEMENT

POLICY NO: ____________________

Any fee for completing this form is the claimant's responsibility.

First and Last Name of the Injured: ______________________________

Address: ______________________________

______________________________ Postal Code ______________

Date of Birth: ______________________________

DETAILS REGARDING THE ACCIDENT

1. Date of the Accident: ______________________________
2. Date of the first consultation following the accident: ______________________________
3. Type of Accident:
   - a) Work: ☐
   - b) Motor Vehicle Accident ☐
   - c) Sport: ☐
   - d) Other, specify: ______________________________
4. Among the injuries, is **there any** fracture(s)? ______________

   Specify: ______________________________

   ____
5. Do you notice any contusion(s) or lesion(s) on the body surface were the fracture occurred? ______________

   Specify: ______________________________

   ____

PLEASE ATTACH A COPY OF THE X-RAY PROTOCOL

6. Where the injury (ies) a result of a fight or public disturbance? ______________
7. Was the accident a result of a voluntary or involuntary use of drug(s), substance(s) or toxic gas? ______________
8. Was a blood test done in order to determine the level of alcohol in the blood? ______________

   If yes, provide the result ______________________________
9. Name and address of the attending physician (In capital letters) ______________________________

   ____

   ____

   Speciality: ______________

   Licence number: ______________

X ______________________________ ______________________________

ATTENDING PHYSICIAN SIGNATURE **DATE**

EQC028 (11-04)

UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.

AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

In order to assess insurability, maintain our file and claims assessment, we authorize any person or institution holding personal information about us including any health information, medical history or eligibility for claims, to transmit such information to UL Mutual or its reinsurers upon request. This includes doctors or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, the Medical Information Bureau, personal information agencies, financial advisors, any financial institution, the policy owner, our employer or previous employer, the Commission de santé et sécurité du travail or other Workmen's Compensation Board, Canada or Quebec Pension Plan, Société de l'assurance automobile du Québec or other Department of Motor Vehicles, la Régie de l'assurance médicaments du Québec or other provincial Health Department, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Likewise, we authorize UL Mutual to transmit the information to its reinsurers as well as to a third party. For the same purpose and to gather the same type of information, we also authorize **UL Mutual** or its reinsurers to request an investigative report about us and to use information in their possession in other files. This consent is also valid for gathering, use and transmission of personal information concerning our minor children. No modification or alteration of this consent will affect its content nor bind the insurer. This consent may also be used for a request for additional insurance or a contract modification.

A photocopy of this agreement shall be as valid as the original.

Signed at ________________________________, this _____________________ 20 _________

X ___________________________________
WITNESS

X ___________________________________
SIGNATURE

ADDRESS _________________________

____

____

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ▪ Phone: 819 478-1315 ▪ Toll free: 1 800 567-0988 ▪ Fax: 819 474-1990
UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.