UV INSURANCE

CLAIM FORM
ACCIDENT INSURANCE

CLAIMANT'S STATEMENT **POLICY NUMBER**: ________________________

This form must be completed by the insured person, if 14 years or older. Otherwise, or if the insured person is unable to, the father, mother, legal guardian or legal representative of the insured person can complete it.

Last name and first name of the insured person
____

Date of birth ______/______/______
Year Month Day

Sex ☐ F ☐ M

Address of the insured person
____
____

Home Telephone No. : (____)________________
Work Telephone No. : (____)________________

Date of accident ______/______/______
Year Month Day

Time of accident _________ ☐ AM ☐ PM

Place of accident ____
____

Description of the circumstances of the accident ____
____

Type of accident
☐work related ☐motor vehicle ☐sport ☐ ________________________
Other, please specify

Nature of injuries
____

Had you consumed any alcoholic beverages or narcotics before the accident? ☐ Yes ☐ No

If yes, specify____

Attending physicians
______________________________ ______________________________
Name and address Name and address

Is the insured person covered by another insurance plan (employer or other insurance)? ☐ Yes ☐ No

Company: ______________________________ Contract No. : ______________________________

Name of primary insured: ______________________________ Certificate No. : ______________________________

Are the benefits under which this claim is submitted covered by this other insurance? ☐ Yes ☐ No

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

X______________________________ ______________________________
SIGNATURE OF THE INSURED PERSON (14 YEARS OR OLDER) DATE

______________________________ ______________________________
CLAIMANT'S LAST AND FIRST NAME (IF CLAIMANT IS NOT THE INSURED PERSON) RELATIONSHIP TO INSURED PERSON

____
CLAIMANT'S ADDRESS (IF CLAIMANT IS NOT THE INSURED PERSON)

X______________________________ ______________________________
CLAIMANT'S SIGNATURE DATE

AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

For the sole purpose of managing files and processing claims, we authorize any person or institution holding personal information about us including, but not limited to, any health information, medical history or eligibility for claims, to transmit such information to UL Mutual or its reinsurers upon request. This includes, but is not limited to, doctors or other practitioners, hospital, medical clinic or paramedical companies, laboratories, insurance companies or reinsurers, the MIB Inc., personal information agencies, financial advisors, any financial institution, the policy owner, our employer or previous employer, the CSST or other Workers' Compensation Board, Canada or Quebec Pension Plan, the SAAQ or other Department of Motor Vehicles, the RAMQ 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 authorization is also valid for the gathering, use and transmission of personal information concerning our minor children. No modification or alteration of this authorization will affect its content nor bind the insurer.

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

X ____ ______________________________
SIGNATURE OF THE INSURED PERSON (14 YEARS OR OLDER) DATE

____ ______________________________
CLAIMANT'S LAST AND FIRST NAME (IF CLAIMANT IS NOT THE INSURED PERSON) RELATIONSHIP TO INSURED PERSON

____
CLAIMANT'S ADDRESS (IF CLAIMANT IS NOT THE INSURED PERSON)

X ____ ______________________________
CLAIMANT'S SIGNATURE DATE

PROCEDURE

Please submit the claim form, required documents, original invoices and other supporting evidence within 90 days following the date of accident.

Coordination of benefits: If the insured person is covered by another insurance plan (public, private or group insurance plan), your claim must first be settled with the company or organization that provides this insurance. Afterwards, a copy of this settlement must be sent to us.

REQUIRED DOCUMENTS

Fracture or dislocation: written confirmation from physician or copy of written radiology report.

Wheelchair, crutches and orthopaedic appliance: medical recommendation stating the duration of the rental or original invoice at the end of the rental.

Transportation: transportation details (dates, places of departure and arrival, distances travelled).

Chiropractor, physiotherapist, osteopath, podiatrist, speech therapist, audiologist or psychologist : medical recommendation and original invoices stating the reason for treatment, date and cost of each visit.

Medication: invoice showing the name of the medication and proof of payment from other insurer (public, private or group insurance).

Death, dismemberment, disability (students 4 to 24 years) and dental expenses: please contact us.

Other expenses incurred and provided for in the contract: original invoices.

Please note that additional documents or information may be required.

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