UV INSURANCE

GROUP INSURANCE

Claim for Compensation for Accidental Loss of a Limb, Sight, or Paralysis

Group number _____ Certificate number _____

Section A—Claimant's Statement

Member Information

1. First name _____ Last name _____
2. Date of birth └ , , , , ┘└ , , ┘└ , , ┘ 3. Gender at birth ☐ F ☐ M
4. Address _____
   City _____ Province _____ Postal code _____
5. Work phone number └ , , , ┘└ , , , ┘└ , , , , ┘ 6. Home phone number └ , , , ┘└ , , , ┘└ , , , , ┘

Accident Information

1. Date of the accident └ , , , , ┘└ , , ┘└ , , ┘ 2. Time of the accident _____ ☐ a.m. ☐ p.m.
3. Location of the accident _____
4. Circumstances leading to the accident

5. Type of accident ☐ work-related ☐ motor vehicle ☐ sport injury ☐ other _____
6. Nature of injuries _____
7. Member's attending physician

Full name of attending physician	Hospital or clinic

8. Was surgery performed? ☐ Yes ☐ No
   If yes, please indicate the date └ , , , ┘└ , , ┘└ , , ┘ nature of the surgery _____

I hereby understand and agree that the collection of my personal information allows UV Assurance to analyze my application. I acknowledge that if any of my personal information is inaccurate, incomplete or ambiguous, I may request that it be corrected by submitting a request to UV Insurance.

I may withdraw my consent to the disclosure or use of my personal information at any time. I understand that withdrawing my consent may have legal or contractual consequences. For example, I understand that UV Insurance may not be able to provide me with a product or process a request. UV Insurance will explain these consequences to me. these consequences.

Upon request, I may receive personal information collected from me:

- ▶ categories of individuals who have access to this information within UV Insurance;
- ▶ duration of retention of this information;
- ▶ contact information for the individual responsible for the protection of personal information.

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

X _____ Date └ , , , ┘└ , , ┘└ , , ┘
Signature of the insured person

_____ _____
Claimant's name (if claimant is not the insured person) Relationship of claimant with the insured person

_____
Claimant's name (if claimant is not the insured person)

X _____ Date └ , , , ┘└ , , ┘└ , , ┘
Claimant's signature

EN-5026A (2025-03)

Group Number _____ Certificate Number _____

Section B–Attending Physician's Statement

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

Insured's Information

1. First name _____ Last name _____
2. Date of birth └┴┴┘└┴┘└┴┘

Accident and Loss of Sight Information

1. Date of the accident └┴┴┘└┴┘└┴┘
2. Type of accident ☐ work-related ☐ motor vehicle ☐ sport injury ☐ other _____
3. At the time of the accident, was the person under the influence of narcotics, alcohol, hallucinogens, drugs not prescribed by a physician, poison, gas or gasoline? ☐ Yes ☐ No

   If yes, please give details and test results _____
4. Description of the loss of sight _____
5. Is the loss of sight the direct and sole result of the injuries sustained in the accident? ☐ Yes ☐ No
6. Amputation level or % of the loss of sight _____ Date of the loss of sight └┴┴┘└┴┘└┴┘

Loss of Sight

1. Date of last examination └┴┴┘└┴┘└┴┘

	Left Eye	Right Eye
Visual acuity		
Visual acuity with glasses		
The vision can be entirely or partially corrected with:	☐ Glasses ☐ Treatments ☐ Operations ☐ No possibility	☐ Glasses ☐ Treatments ☐ Operations ☐ No possibility

2. Is the loss of sight the direct result of the accident, with no influence from any other cause? ☐ Yes ☐ No

   If no, please explain _____

Paralysis

1. Did the accident result in one of the following? ☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia
2. Start date of the paralysis └┴┴┘└┴┘└┴┘
3. Is the accident the only cause of the paralysis? ☐ Yes ☐ No
4. If the paralysis is not the result of an accident, what medical history led to the paralysis?

   _____
5. Is the paralysis permanent, total and irremediable? ☐ Yes ☐ No
6.

	Name of the attending physician	Hospital or clinic	Date
Other attending physicians			└┴┴┘└┴┘└┴┘
Hospital or other institution treating the injured person			└┴┴┘└┴┘└┴┘

7. Comments

Section C–Attend Physician Information

1. Full name of attending physician _____
2. Speciality _____ 3. Licence number _____
4. Hospital or clinic _____

X _____ Date └┴┴┘└┴┘└┴┘

Attending physician's signature

EN-5026A (2025-03)