iA Financial Group

Return to:
Life and Health Claims Dept., Special Market Solutions
400–988 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Claimant's Statement
Preliminary Proof of Loss

Please print in ink

Policyholder's Name | Policy No.: | Claim No.:

Claimant's Statement

Claimant's Name | Age | Date of Birth (D D / M M / Y Y Y Y) | S.I.N.

Mailing Address/Street:

City | Province | Postal Code | Phone Number

1. a) When did you become injured/sick? _____ (dd/mmm/yyyy) b) When did you quit work? _____ (dd/mmm/yyyy) at _____AM/PM
2. What were you doing when injured? _____
3. What sickness or injury was suffered? _____
4. How did accident occur? Describe: _____
   Attach diagram or sketch if necessary
5. Have you had a similar sickness or injury before? ☐ Yes ☐ No
   Give dates and details: _____
6. Witnesses (Names and addresses):
   _____
   _____
7. Name of Physician: _____
   Address: _____
8. Where and when did your Physician first attend you? ☐ Home ☐ Office ☐ Hospital
   Date: _____ (dd/mmm/yyyy) Time: _____ ☐ AM ☐ PM
9. Has any other physician treated you for this accident or sickness? ☐ No ☐ Yes If "Yes", when? _____ (dd/mmm/yyyy)
   Physician's name and address:
   _____ _____
10. What medical attendance have you had during the past five years? _____
11. a) What is your present occupation? _____ b) What is your monthly salary? $_____ ___
12. Employer's name and address: _____
13. What other accident or health insurance do you have?
    Company: _____ Amount: _____
14. Are you receiving or have you applied for a disability pension, WSIB or unemployment benefits? ☐ No ☐ Yes
    If "Yes", for what? _____ Amount $ _____ Date of first payment _____ (dd/mmm/yyyy)
15. a) Are you/were you totally disabled? ☐ Yes ☐ No If "**YES**", from: _____ to: _____
    b) Are you/were you house confined? ☐ Yes ☐ No If "**YES**", from: _____ to: _____
    c) Are you/were you hospitalized? ☐ Yes ☐ No If "**YES**", from: _____ (dd/mmm/yyyy) to: _____ (dd/mmm/yyyy)
    If "Yes", name and address of hospital
    _____
16. a) When did you or will you resume part-time work? Date: _____ Time: _____ AM/PM
    b) When did you or will you resume full-time work? Date: _____ (dd/mmm/yyyy) Time: _____ AM/PM

I hereby certify that the above answers are both true and complete.

I acknowledge receipt of the attached Authorization and Declaration.

Dated _____ (dd/mmm/yyyy) Signature of Claimant _____

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION

Attending Physician's Statement

Please return completed form to your patient

1. Patient's Name: _____ Age _____
2. Is condition due to injury/sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
3. Diagnosis of present condition
   a) Primary
   b) Secondary (if applicable)
   c) If appropriate - additional conditions which might affect the duration of disability

   _____
4. To the best of my knowledge
   a) Symptoms first appeared or accident happened (D D / M M / Y Y Y Y)
   b) Patient has had same or similar condition ☐ Yes ☐ No

      If "Yes", state when and describe: _____
5. Date of hospital in-patient admission (D D / M M / Y Y Y Y) Date of Discharge (D D / M M / Y Y Y Y)
6. If surgery performed, describe

   _____ _____ Date (D D / M M / Y Y Y Y)
7. If referred to you, give name of referring physician: _____
8. a) Date of first visit for present period of disability (D D / M M / Y Y Y Y) b) Date of latest attendance (D D / M M / Y Y Y Y)

   c) Were you actively supervising this patient's care during the full period?

      ☐ No If "No", please comment in Question 12.

      ☐ Yes If "Yes", state frequency of visits. ☐ Weekly ☐ Monthly ☐ Other (specify) _____
9. If condition is due to pregnancy, what is (or was) the expected date of confinement? (D D / M M / Y Y Y Y)
10. a) To the best of my knowledge, the patient has been **Totally** disabled (Unable to work).

    From: (D D / M M / Y Y Y Y) To: (D D / M M / Y Y Y Y) Inclusive

    b) If still disabled, give approximate date when patient should be able to return to work. (D D / M M / Y Y Y Y)

    or, if indefinite, the estimated number of additional weeks before such return _____ additional weeks.
11. How long was or will patient be **Partially** disabled (Able to work part-time at own occupation)?

    From: (D D / M M / Y Y Y Y) To: (D D / M M / Y Y Y Y) Inclusive
12. How does present condition affect patient's ability to work? _____

    Additional remarks: _____

    _____

Physician's Name

Mailing Address/Street:

City Province Postal Code Phone Number

Physician's Signature *Date Signed* (D D / M M / Y Y Y Y)

_____ *MD*