HUMANIA ASSURANCE MD®

Critical illness
Child insurance - Initial statement

For information, please contact us at: in the Saint-Hyacinthe region at 450-773-5783, elsewhere at 1 877 987-3076.
Web site: www.humania.ca, Email: claims@humania.ca

Part 1 - Information

Part A - Policyholder's / Insured's statement

Policy:

Name:

First Name:

Social Insurance Number: Date of birth: year / month / day

Relationship with the Person Insured: ☐ Father ☐ Mother ☐ biological ☐ legally recognized ☐ Legal guardian

Address: (number and street) (apt.)

City:

Province: Postal Code: Main Telephone Number:

Other Telephone Number:

Part B - Information on the child / Person Insured

Name:

First Name:

Date of birth: year / month / day

Address: (number and street) (apt.)

City:

Province: Postal Code:

4300-030-en
2022/02

Part 2 - Diagnosis

Please describe the nature and extent of the critical illness:

When did the symptoms first appear? Date: year / month / day

Please indicate first visit with medical pratitioner for the current illness: Date : year / month / day

Please indicate the name and address of the Attending Physician:

Name of the Physician:

Address: (number and street)

City:

Province: Postal Code: Main Telephone Number:

Please provide details of doctors or specialists consulted in connection with the critical illness:

Doctor's name	Address

Please provide details on hospitals or similar institutions where the Person Insured has been treated:

Hospital's name	Address

Part 3 - Authorization

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer or any other person or organization in possession of information concerning myself and the Person Insured to release to Humania Assurance, its agents and service providers all medical, financial or other information deemed relevant in the assessment of this claim.

I authorize Humania Assurance, its agents and service providers to conduct all necessary investigations required in order to verify the validity of this claim. I accept that Humania Assurance will use the information provided for this claim and any prior claims under the same plan for the management of this claim and for production or statistical reports.

This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is a valid as the original.

Name (please print): _____ Signature: _____

Child's Name (please print): _____ Date: ☐☐☐☐ / ☐☐ / ☐☐
year / month / day

This claim statement must be completed by the Policyholder/Insured, who must be the legal guardian, biological or legally recognized mother or father.

Humania Assurance Inc., 1555, Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6