HUMANIA ASSURANCE MD®

INDIVIDUAL INSURANCE

COMPASSIONATE LEAVE BENEFIT - CRITICAL ILLNESS

For information, please contact us at: 1 877 987-3076 • Fax: 1 877 660-2519
Our address is: 1555 Girouard Strret West, Saint-Hyacinthe (Quebec) J2S 2Z6 • Email: claims@humania.ca • Web site: www.humania.ca

Policyholder statement

To be completed by the Policyholder/Insured.

Part 1 – Information

Information on the Person Insured		
Policy		
Name	First Name	
Information on the Policyholder/Insured		
Name	First Name	
Social Insurance Number	Date of birth (YYYY/MM/DD)	
Relationship with the Person Insured ❑ Father ❑ Mother ❑ biological ❑ legally recognized ❑ Legal guardian		
Address		
City	Province	Postal Code
Main Telephone N°	Other Telephone N°	
Information on the Family Member on an unpaid leave of absence if different from the Policyholder		
Name	First Name	
Date of birth (YYYY/MM/DD)		
Relationship with the Person Insured ❑ Father ❑ Mother ❑ Child ❑ biological ❑ legally recognized ❑ Legal guardian ❑ Spouse		
Address		
City	Province	Postal Code
Main Telephone N°	Other Telephone N°	

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Policyholder statement

To be completed by the Policyholder/Insured. The Family Member is the one identified on the present claim as on an unpaid leave of absence

Part 2 – Declaration of an unpaid leave of absence

Last day worked by the Family Member. (YYYY/MM/DD)

First day of the Family Member's leave of absence. (YYYY/MM/DD)

Is the Family Member? ❑ Contractual ❑ Student ❑ On call ❑ Salaried ❑ Unemployed ❑ Self-employed

Does the Family Member usually work: ❑ Full time ❑ Part-time

Regular schedule: _____ hrs/week _____weeks/year

Since the last day worked indicated above, has the Family Member performed any professional activities?

❑ Yes from (YYYY/MM/DD) to (YYYY/MM/DD)

❑ No

Please detail why the Family Member is unable to work?

Is the date of return to work or restart of professional activities known?

❑ Yes If so, please detail (YYYY/MM/DD) ❑ No

Part 3 – Other income information

If the Family Member applied for, or is receiving any income from any of the following sources, please complete the appropiate section below and submit a copy of the notice of acceptance or refusal, if applicable.

Source	Has a claim been submitted?		Are benefits beeing received?			Monthly Amount
	Yes	No	Yes	No	Pending	
Employment Insurance (regular, sickness or compassionate care)	❑	❑	❑	❑	❑	
Other insurer	❑	❑	❑	❑	❑	
Worker's Comp – CSST, WSIB, WCB	❑	❑	❑	❑	❑	
Crime victims compensation (IVAC)	❑	❑	❑	❑	❑	
Quebec Pension Plan (QPP) – Disability	❑	❑	❑	❑	❑	
Quebec Pension Plan (QPP) – Disability	❑	❑	❑	❑	❑	
Provincial auto insurance – SAAQ	❑	❑	❑	❑	❑	

Part 4 – Policyholder's authorization and declaration

As policyholder of this insurance policy, I certify that the information contained in this form is accurate and complete. At the same time, I certify that the family member identified in this claim is on an unpaid leave of absence for the period detailed in Part 2 of this form.

I authorize Humania Assurance, its agents, service providers and other partners (hereinafter «Business Partners») to collect, by any electronic means, email fax or mail and to use all personal information relevant to the adjudication of the claim submitted under this insurance policy as well as for statistical purposes.

I further authorize Humania Assurance to exchange the personal information collected about me with its Business Partners, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

This authorization applies to my personal information held by any natural or legal person, including but not limited to: any physician or other health professional any public or private health institution, any rehabilitation company, any pharmacist, any provincial health insurance plan, including but not limited to the Régie de l'assurance maladie du Québec, any insurer, any employer or any other person or institution in possession of medical or financial information about me. This authorization also applies to any other persona! information contained on social media or on any Internet platform accessible to the public.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

By providing my email address below, I authorize Humania Assurance to communicate with me by email concerning my present claim.

I declare that I am aware of the rights granted by the Act respecting the protection of personal information in the private sector; including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my persona! information.

Name	Signature
Policy no.	Email address
Date (YYYY/MM/DD)	

Part 5 – Direct Deposit

Policyholder's type of bank account

❑ Chequing ❑ Saving Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

Branch no. (5 digit number)	Institution no. (3 – 4 digit number)	Account no. (All numbers)
Financial institution name		
Financial institution address		

Authorization

I authorize Humania Assurance to use and disclose the bank account information in this authorization to Canada-wide financial institutions, using any electronic means, email, fax or mail, for the purpose of crediting benefit payments associated with this claim to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Humania Assurance of any subsequent changes.

I declare that I am aware of the rights granted by the Act respecting the protection of personal information in the private sector, including but not limited to the right to access information in the file that pertains to me, the right to have that information corrected, if need be, and the right to withdraw my authorization at any time.

Insured signature	Date (YYYY/MM/DD)
Account holder signature (if other than insured)	Date (YYYY/MM/DD)

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Employer statement

Important : To be completed by the Family Member's employer.

Part A – Employer information

Name of employer	Name of subsidiary or division (if different)
Address (no., street)	

City	Province	Postal Code	Telephone No.

Part B – Employee information

Surname	Given name(s)

What was the employee's date of hire? (YYYY/MM/DD)	Last date of work? (YYYY/MM/DD)	Forseen return to work date? (YYYY/MM/DD)

Was the employee ❑ Salaried ❑ Hourly ❑ On call ❑ Contractual

The employee usually works:

❑ Part-time ❑ Full time _____ hrs/week and _____ weeks/year

What is the employee's main reason for absence?

❑ Illness ❑ Vacations ❑ Unpaid leave of absence Other _____

Since the last day worked, indicated above, has the employee performed any professional activities for you?

❑ No ❑ Yes, for the period of (YYYY/MM/DD) to (YYYY/MM/DD)

Has the employee received a salary since his las day worked? ❑ Yes ❑ No

Has the employee submitted a claim to the following government bodies?

❑ WSIB/WCB/CSST ❑ Employment insurance (Please enclose a copy of the record of employment form) ❑ CPP ❑ QPP

❑ SAAQ – Provincial automobile insurance board ❑ Crime Victim Compensation Act

I certify that the information given above is true and complete.	Date (YYYY/MM/DD)

Name (please print)	Téléphone no.

Signature of the authorised person	Job title

HUMANIA ASSURANCE INC.

1555, Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6
Saint-Hyacinthe region : 450 773-5783
Elsewhere : 1 877 987-3076
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