HUMANIA ASSURANCE

INDIVIDUAL INSURANCE

COMPASSIONATE LEAVE BENEFIT - CRITICAL ILLNESS

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

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°	

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

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

I certify that the information contained in this form is true and complete.

I certify that the family member identified in this claim is on a unpaid leave of absence for the period detailed in Part 2 of this form.

I authorize Humania Assurance to conduct all necessary investigations required in order to verify the validity of my claim.

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance all medical, financial or other information deemed relevant in the assessment of my claim.

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
Policy no.	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 Inc., to credit all my benefit payments to the account mentionned on this form. I certify that information provided on this form is accurate, and I agree to inform Humania Assurance Inc., of any subsequent changes. I accept that this agreement may be cancelled at any time by either Humania Assurance, myself, in writing or verbally.

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

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

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
Web site: www.humania.ca

4300-031-en - Rev. 08/2015