

Claimant's statement

Last name of insured:

First name of insured:

Date of birth: / / Policy number:

day / month / year

Address: (apt.)

(number and street)

City:





Province: Postal Code:

Home phone number: Cellular number:

Email address:

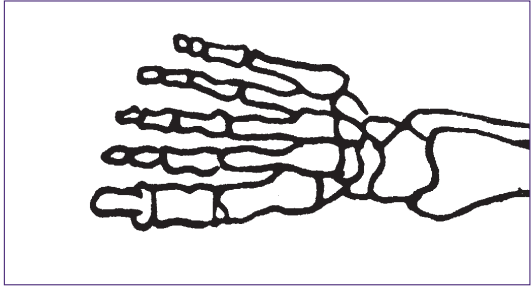
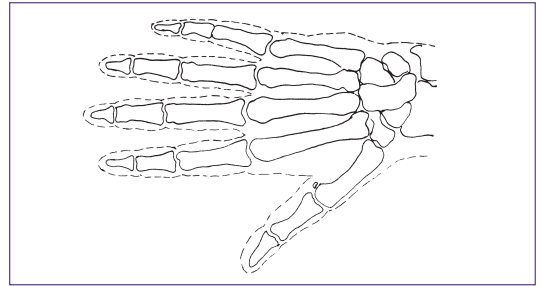
Please indicate the site of amputation

Limb loss

	Right arm	Date <input type="text"/> / <input type="text"/> / <input type="text"/>
	Right leg	Date <input type="text"/> / <input type="text"/> / <input type="text"/>
	Left leg	Date <input type="text"/> / <input type="text"/> / <input type="text"/>
	Left arm	Date <input type="text"/> / <input type="text"/> / <input type="text"/>

Right hand (dorsal view)

Right foot



It is important to answer every question

1- Provide: a) The date of the accident: / / b) The time: At _____ hours A.M. P.M.
day / month / year

2- Place of the accident (specify if possible the civic address and indicate if it is a residence, a public building, a road, a construction site, etc.)

3- In what activity were you engaged in when the accident occurred? _____

4- Provide the details of the accident (how did it occur?).

5- Was there a police report? Yes No **If yes**, please attach a copy.

6- If it is a road accident, a claim for damages was made with a public or private insurer? Yes No

If yes, please specify: Name of the insurer _____
 Folder number (if known) _____
 Names of witnesses _____

7- Provide the name(s) of the attending physician(s)?

Name of the physician or the hospital	Address	Date of admission	Discharge date

8- What mutilation(s) did you suffer(s)? (Please attach the operative protocol and/or the radiological protocol)

9- Date of 1st treatment by a physician for this incident / /
day / month / year

10- Was there any disability or infirmity prior to the accident? Yes No **If yes**, please provide details.

I authorize all physicians that have treated me or any hospital where I have stayed to provide Humania Assurance Inc. with any information it requires regarding my health or the accident described above.

Dated _____, _____ 20_____

_____ Witness _____ Claimant