HUMANIA ASSURANCE MD®

# Claim Form for Critical Illness Insurance Benefit
## Proof of claim - Claimant's Statement

## Part 1 - Claimant's Statement

Policy:

Name:

First Name:

Sex: ☐ Male ☐ Female

Date of birth: Year / Month / Day

☐ Smoker ☐ Non-smoker

If yes, Since when? day / month / year

If you stop, Since when? day / month / year

Address: (number and street) (apt./suite)

City:

Province: Postal Code:

Telephone Nº:

## Part 2 - Claim and Related Details

a) Please describe the nature and extent of your Critical Illness.

On what date was your condition diagnosed or surgery performed? Date: Year / Month / Day

b) On what date did the symptoms first appeared or started? Date: Year / Month / Day

Please describe these symptoms:



4300-045-en
2018/08

## Part 2 - Claim and Related Details (...continued)

c) Indicate first visit with medical practitioner for the current illness. Date: Year / Month / Day

Please indicate the name and address of the Physician seen:

Name of the Physician:

Telephone Nº:

Address: (number and street) (apt./suite)

City:

Province: Postal Code:

d) Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates.

e) Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No

If yes, please give details including dates.

## Part 3 - Medical Consultations

a) Please provide the Name and Address of your personal physician.

Name of the Physician:

Telephone Nº:

Address: (number and street) (apt./suite)

City:

Province: Postal Code:

## Part 3 - Medical Consultations (...continued)

b) Please provide details of any other doctors or specialists who have been consulted in connection with your illness:

| **Name** | **Address** (Number, street, city, province, postal code) | **Telephone** (Including are code) | **Dates seen** (Year, Month, Day) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

c) If you have been treated at hospital or similar institution, please supply the following information:

| **Name of Hospital** | **City or Town** | **Date of admission** (Year, Month, Day) | **Date of discharge** (Year, Month, Day) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

d) What other treatment have you received and are you currently receiving in connection with your condition? (e.g., medications, therapy, etc.)

| **Type of treatment** | **Institution** | **Prescribing Physician** | **Dates** (Year, Month, Day) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Part 4 - General

a) Has any member of your family suffered from a similar or related condition? ☐ Yes ☐ No

If yes, please indicate:

| Relationship | Nature of Illness | Age at Which Illness was First Diagnosed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

b) Are you insured/ or benefits related to this condition from another company ☐ Yes ☐ No

If yes, please indicate:

| Name of Insurer | Type of Benefit | Amount of Benefit Insured | Has a Claim been Submitted? |
|---|---|---|---|
| | | $ | ☐ Yes ☐ No |
| | | $ | ☐ Yes ☐ No |
| | | $ | ☐ Yes ☐ No |

c) Do you smoke or use tobacco products? ☐ Yes ☐ No

If YES, please indicate amount per day. _____

How long have you used tobacco? _____

If NO, did you previously use tobacco products? ☐ Yes ☐ No

On what date did you quit? ☐☐☐☐ / ☐☐ / ☐☐
Year / Month / Day

d) Please provide any further information which you think might be helpful in support of your claim.

_____

_____

Signature: _____ Date: ☐☐☐☐ / ☐☐ / ☐☐
Year / Month / Day

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