INDIVIDUAL INSURANCE

# DISABILITY CLAIM FORM

Initial assessment

*In order to ensure confidentiality of personal information, Humania Assurance will establish a claim file in which information concerning all of your claims will be kept. Only employees or authorized agents of Humania Assurance responsible for the management of your claim shall have access to the file.*

## Is your file complete?

Have you included all of the following documents, duly completed, signed and dated:

- ❑ Claimant/insured's statement
- ❑ Employer's statement (even if the event did not occur in the workplace or you are self-employed)
- ❑ Appropriate attending physician statement for your diagnosis (physical or psychological)
- ❑ Signed authorization forms
- ❑ Direct deposit form

If you are an employee, please send us:

- ❑ A complete copy of your most recent tax return **AND** related Notice of Assessment **OR**
- ❑ A copy of your most recent T4s and Relevé 1

If you are a business owner or self-employed, please send us:

- ❑ A complete copy of your most recent tax return **AND** related Notice of Assessment, **AND**
- ❑ A complete copy of your most recent financial statements **AND**
- ❑ A legal document confirming your share in the company if applicable

If your policy covers debt:

- ❑ A copy of your bank statement for the month prior to your date of disability including proof of no disability insurance
- ❑ A complete copy of the contract(s) (loan, credit, etc.) in support of the debt(s)

If your policy covers a fracture

- ❑ A copy of the radiology report used to diagnose the fracture

If your disability occurs within two (2) years of your insurance policy being issued:

- ❑ Complete the correct Authorization for disclosure of information for your province by visiting: https://www.humania.ca/en-CA/individual/claims-forms/make-a-claim

## Direct Deposit – Authorization (not valid if the beneficiary is a financial institution)

❑ Initial Request ❑ Request for bank account change

### I Insured statement (please print)

Please enter all policy numbers for which the authorization is valid.

| Policy n° | Policy n° | Policy n° |
|---|---|---|

| Insured surname | Given name(s) |
|---|---|

| Telephone no. (day) | Main residence address (no., street) | Apt. |
|---|---|---|

| City | Province | Postal code |
|---|---|---|

| Financial institution name | Financial institution address |
|---|---|

### II Type of bank account (please print). Please complete this section AND ATTACH A SAMPLE CHEQUE

❑ Chequing ❑ Savings ❑ My bank details are the same as those used for premium deductions

Please complete this section or attach a sample cheque that will allow us to obtain your accurate banking information.

| Branch no. (5-digit number) | Institution no. (3 – 4 digit number) | Account no. |
|---|---|---|

### III 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 (DD/MM/YYYY) |
|---|---|
| Account holder signature (if other than insured) | Date (DD/MM/YYYY) |

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

## Claimant statement

**To be completed by the claimant. All questions must be answered in as much detail as possible. Please print.**

### Section A – General information

| | | |
|---|---|---|
| Sex ❑ Male ❑ Female ❑ Prefer not to say | Date of birth (DD/MM/YYYY) | Policy n° |

| | |
|---|---|
| Surname | Given name(s) |

Address (no., street)

| | | | | |
|---|---|---|---|---|
| City | Province | Postal code | Telephone no. | Language ❑ Fr. ❑ En. |
| Home phone number | Cell phone number | Email | | |

| | | |
|---|---|---|
| Name of employer *(and division if different)* | Occupation *(just prior to last day worked)* | Original date of hire (DD/MM/YYYY) |

Other current employer ❑ Yes ❑ No If yes, please name.

Nature of request for benefits ❑ Disability ❑ Waiver of premiums ❑ Fracture

### Section B – Claim information

Have you stopped working or performing your daily activities due to ❑ illness ❑ injury away from work ❑ motor vehicle accident (not while working) ❑ occupational illness or work accident.

**Please tell us, in as much detail as possible, the circumstances under which the disability occurred.**

Were you ❑ Performing your regular dutiel ❑ Unemployed

| | |
|---|---|
| Was this a full day? ❑ Yes ❑ No | If no, how many hours did you work on your last day? |
| Date you were first unable to work or perform your daily activities (DD/MM/YYYY) | When did you first notice these symptoms? (DD/MM/YYYY) |

When did you first consult a physician for this condition? (DD/MM/YYYY)

Please describe all of your symptoms, including frequency and severity.

Have you ever had the same or similar illness or injury? ❑ Yes ❑ No
If yes, please provide the dates and name(s) of the physician(s) who treated you at the time.

Please describe the major duties of your occupation. If you are unemployed or retired, please describe your daily activities.

## Claimant statement (continued)

### Section B – Claim information

Have you been called to your workplace since the date of disability?

What tasks have you continued to do since the date of disability?

Please describe why you are unable to perform the duties of your occupation or your daily activities.

Please indicate if you are ❑ Right-handed ❑ Left-handedr

Do you have an expected date of return to work or resumption your daily activities?
❑ Yes If yes, please provide the date (DD/MM/YYYY) ❑ No

### Section C – Health care professionals information

Please list all health care professionals **you have consulted in the last 12 months,** starting with the most recen , including family physicians , specialists, chiropractors, psychologists, etc. . If the space provided below is insufficient, please attach a separate page to this form with the names of other health care professionals you have contacted.

| | | |
|---|---|---|
| Name | | Consulted from (DD/MM/YYYYD) to (DD/MM/YYYY) |
| Address (no., street) | | |
| Telephone no. | Fax no. | Specialty |
| Name | | Consulted from (DD/MM/YYYY) to (DD/MM/YYYY) |
| Address (no., street) | | |
| Telephone no. | Fax no. | Specialty |
| Name | | Consulted from (DD/MM/YYYY) to (DD/MM/YYYY) |
| Address (no., street) | | |
| Telephone no. | Fax no. | Specialty |

## Claimant statement (continued)

### Section D – Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the appropriate section below and **submit a copy of your notice of acceptance or refusal, if applicable.**

| Source | Claim no., contact name, telephone no. | Have you applied? | | | Are you receiving payments? If yes, provide the benefit statement | | | Amount |
|---|---|---|---|---|---|---|---|---|
| | | Yes | No | Date | Yes | No | Pending | |
| Worker's compensation – CNESST, WSIB, WCB | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Crime victims compensation (IVAC) | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Canada Pension Plan – Disability | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Canada Pension Plan – Retirement | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Quebec Pension Plan (QPP) – (RQ) – Disability | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Quebec Pension Plan (QPP) – Retirement | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Employment Insurance | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Provincial auto insurance – SAAQ | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Individual insurance | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Group insurance | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |
| Debt or overhead insurance | | ❑ | ❑ | (DD/MM/YYYY) | ❑ | ❑ | ❑ | |

### Section E – Claimant authorization and declaration

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 or for statistical reporting purposes.

I further authorize Humania Assurance to exchange the personal information collected about me to 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 personal 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 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 personal information.

Name (please print) ____________________ Signature ____________________

Policy no. ____________________ Date (DD/MM/YYYY) ____________________

Email address ____________________

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## Employer or self-employed statement

**Important: Even if the accident is not work related, please have the employer complete this statement or, if you are self-employed, complete it yourself.**

**Please answer all questions with as much detail as possible and write legibly.**

### Section A – Employer information

| Name of employer | | | Email address | |
|---|---|---|---|---|
| Address (no., street) | | | | |
| City | Province | Postal code | Telephone no. | Ext. |

### Section B – Claimant information

| Surname | | Given name(s) |
|---|---|---|
| Claimant's date of hire (DD/MM/YYYY) | Last day of work (DD/MM/YYYY) | Expected return to work date (DD/MM/YYYY) or expected duration of disability |

If claimant is already back at work, what was the start date? (DD/MM/YYYY)
❑ Part-time ❑ Full-time ❑ Temporary assignment ❑ Light duties ❑ Gradual return to work – Please provide the return-to-work protocol

Please provide the hours of work in a normal week.

Monday ________ Tuesday ________ Wednesday ________ Thursday________ Friday ________ Saturday ________ Sunday ________
*(If claimant works irregular hours or shifts, provide work schedule.)*

What is the claimant's gross annual salary for the year? $ ____________________

Was the employee ❑ Salaried ❑ Hourly ❑ On call ❑ Seasonal
❑ Contractual: If yes, please specify the contract start date and expected end date. DD/MM/YYYY)

Did the claimant receive any income during the disability period? ❑ Yes ❑ No
If yes, please select one of the following:
❑ Vacation ❑ Maternity leave ❑ Employment insurance
❑ Sick days ❑ Statutory holidays ❑ Other ________________
❑ Employment Insurance caregiving benefits

Amount $ ______________________ From ____________________________ to ____________________________

Has the claimant submitted a claim to the following government bodies?
❑ WSIB, CNESST or WCB ❑ Employment insurance (please attach a copy of the record of employment) ❑ CPP ❑ QPP (RQ)
❑ SAAQ or provincial automobile insurance ❑ Crime Victim Compensation Act

### Section C – Occupational information

What was the claimant's regular occupation immediately prior to stopping work?

Please describe this occupation (or attach a copy of the job description) as well as any modifications.

## Employer statement (continued)

The following physical demands analysis of the claimant's occupation is to be completed by their supervisor.

In the appropriate column, specify the amount of time spent on a regular basis on the following activities:
I) at any one time, without break or interruption (approximately) and
II) in total throughout the day (approximately)

**Physical demands analysis (not required for compassionate care leave)**

| | | I | II |
|---|---|---|---|
| 1. Sitting | | | |
| 2. Standing | | | |
| 3. Driving | | | |
| 4. Bendingr | | | |
| 5. Climbing up and down stairs | | | |
| 6. Lifting | 0 – 10 pounds ❑ 10 – 20 pounds ❑<br>20 – 50 pounds ❑ 50 pounds + ❑<br>With lifting device? Yes ❑ No ❑ | | |
| 7. Pushing/Pulling | 0 – 10 pounds ❑ 10 – 20 pounds ❑<br>20 – 50 pounds ❑ 50 pounds + ❑ | | |

Please describe claimant's work environment (e.g., temperature, noise levels, chemical/dust exposure, etc.).

What accommodations are available for your worker?
❑ Remote work ❑ Modified (sedentary or light) duties
❑ Part-time ❑ Other. Please provide details: ______________________

Are there any circumstances or facts that would cause you to question the validity of the claim? ❑ Yes ❑ No If yes, please explain.

| **Email address for claim communications** | Date (DD/MM/YYYY) |
|---|---|
| Name (in print) | Telephone no. |
| Signing authority | Job title |

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## Attending physician statement – physical conditions

**In order for Humania Assurance to properly assess the patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.**

### Section A – Patient Information

| Surname | Given name(s) | |
|---|---|---|
| Date of birth (DD/MM/YYYY) | Height | Weight |

### Section B – Diagnosis

What is the primary diagnosis?

Based on the anamnesis and your clinical examination, is your patient's condition the result of an accidental event? ❑ Yes ❑ No Please provide details:

On what date did the symptoms first appear or the accident occur? (DD/MM/YYYY)

What was the date the patient's first visit with a physician since they stopped working? (DD/MM/YYYY)

On what date did the patient first consult you since the onset of the disability? (DD/MM/YYYY)

On what date did the patient first consult you about their current condition? (DD/MM/YYYY)

Please tell us the date your patient stopped working or performing daily activities, on your recommendation or that of a colleague? (DD/MM/YYYY)

Is there a secondary diagnosis or complications that may prolong the duration of the disability? ❑ Yes ❑ No
If yes, please elaborate.

Please provide a complete list of your patient's symptoms (including severity and frequency). Please state which symptoms you have personally observed.

What are your patient's current limitations (things they **cannot** do)? Please be specific.

What are your patient's current restrictions (things they **should not** do)? Please be specific.

Has the patient ever suffered from the same or a similar condition? ❑ Yes ❑ No If yes, please state when and describe the condition in detail.

Is the patient's condition due to injury or sickness arising out of their employment? ❑ Yes ❑ No If yes, please elaborate.

## Attending physician's statement – physical fitness (continued)

### Section B – Diagnosis (continued)

Is your patient ❑ Right-handed ❑ Left-handed

Is your patient competent to manage his/her own financial affairs? ❑ Yes ❑ No

If your patient was/is pregnant, please indicate the date or expected date of delivery. (DD/MM/YYYY)

### Section C – Treatment

Frequency of patient visits: ❑ Weekly ❑ Bi-weekly ❑ Monthly ❑ Other ______________________________

Has the patient undergone or will the patient undergo:

Medical exams (X-ray, MRI or others): ❑ Yes ❑ No Specify: ______________________________

Surgery: ❑ Yes ❑ No ❑ Day surgery Type: ____________________ Date: (DD/MM/YYYY)

Other surgical intervention: ______________________________

Other treatments: ❑ Yes ❑ No Specify: ______________________________

Hospitalization from (DD/MM/YYYY) to (DD/MM/YYYY) Name of hospital: ______________________________

A short hospital stay for observation: ❑ Yes ❑ No Number of hours: ______________________________

Please list all medications the patient is currently taking, including dosage and date prescribed.

| Medication | Dosage | Date prescribed (DD/MM/YYYY) |
|---|---|---|
| | | |
| | | |
| | | |

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to specialists, please provide the names of the specialists and area of specialty.

### Section D – Prognosis

If a return to work has been discussed with the patient, please provide the date and indicate if the return is (DD/MM/YYYY)

❑ Part-time ❑ Full-time ❑ Temporary assignment ❑ Light duties ❑ Gradual return to work – Please provide the return-to-work protocol

______________________________

______________________________

How long will the patient's leave of absence be?

❑ Less than 3 months ❑ 3 to 6 months ❑ More than 6 months

| Signature | Date (DDJ/MM/YYYY) | |
|---|---|---|
| Name (please print) | Specialty | Licence No. |
| Address (no., street) | | |
| Telephone No. | Fax No. | |

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## Attending physician statement – psychological condition

**In order for Humania Assurance to properly assess the patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.**

### Section A – Patient Information

| Surname | Given name(s) | |
|---|---|---|
| Date of birth: (DD/MM/YYYY) | Height | Weight |

### Section B – Diagnosis

Please indicate the patient's diagnosis(-es):

Primary diagnosis: ______________________________

Secondary diagnosis: ______________________________

When did symptoms first appear? (DD/MM/YYYY)

What was the date of the patient's first visit with a physician since they stopped working? (DD/MM/YYYY)

On what date did the patient first consult you since the onset of the disability? (DD/MM/YYYY)

On what date did the patient first consult you about their current condition? (DD/MM/YYYY)

Please tell us the date your patient stopped working or performing daily activities, on your recommendation or that of a colleague. (DD/MM/YYYY)

Please provide a complete list of your patient's symptoms (including severity and frequency). Identifying which if the symptoms listed you have objectively observed

Is the patient's condition caused directly or indirectly by their employment? ❑ Yes ❑ No If yes, please elaborate.

Has the patient ever suffered from the same or a similar condition? ❑ Yes ❑ No
If yes, please state when and describe the condition in detail.

Is your patient competent to manage his/her own financial affairs? ❑ Yes ❑ No

## Attending physician's statement – psychological condition (continued)

### Section C – Treatment

Frequency of patient visits: ❑ Weekly ❑ Bi-weekly ❑ Monthly ❑ Other ______________________

Will you see the patient again? If yes, when?

| Type of therapy | Name of provider or facility | Treatment start date (DD/MM/YYYY) | Frequency of visits | Date of last visit (DD/MM/YYYY) | Response |
|---|---|---|---|---|---|
| | | | Weekly ❑<br>Monthly ❑<br>Other ❑ | | |
| | | | Weekly ❑<br>Monthly ❑<br>Other ❑ | | |
| | | | Weekly ❑<br>Monthly ❑<br>Other ❑ | | |
| | | | Weekly ❑<br>Monthly ❑<br>Other ❑ | | |

Was the patient hospitalized? ❑ Yes ❑ No If yes, please provide the name of the hospital and dates of hospitalization.

Please list all medications the patient is currently taking, including dosage and date prescribed.

| Medication | Dosage | Date prescribed (DD/MM/YYYY) |
|---|---|---|
| | | |
| | | |
| | | |

### Section D – Evaluation

1. Complicating factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery:

❑ Workplace issues ❑ Social/family issues ❑ Financial/legal problems
❑ Physical condition ❑ Alcohol/drug abuse ❑ Medication side effects
❑ Pain perception ❑ Coping skills ❑ Personality/motivation ❑ Other

Please describe:

______________________________________________

______________________________________________

Please describe supports in place (or planned) to help the patient with these issues:

______________________________________________

______________________________________________

## Attending physician's statement – psychological condition (continued)

### Section D – Assessment (continued)

Please provide your opinion as to the extent of the patient's impairment in performing the following activities on a sustained basis during a normal workday.

**None**: no impairment in this area.
**Mild**: Slight impairment that does not affect functional ability.
**Moderate**: impairment affects but does not preclude ability to function.
**Moderately severe**: impairment significantly affects ability to function.
**Severe**: extreme impairment on ability to function.

| | None | Mild | Moderate | Moderately severe | Severe |
|---|---|---|---|---|---|
| 1. Ability to relate to friends and family members | ❑ | ❑ | ❑ | ❑ | ❑ |
| 2. Ability to attend to personal care (hygiene, meals, etc.) | ❑ | ❑ | ❑ | ❑ | ❑ |
| 3. Ability to carry out household chores | ❑ | ❑ | ❑ | ❑ | ❑ |
| 4. Ability to relate to co-workers and supervisors | ❑ | ❑ | ❑ | ❑ | ❑ |
| 5. Ability to perform work that calls for minimal contact with others | ❑ | ❑ | ❑ | ❑ | ❑ |
| 6. Ability to understand, carry out and remember instructions | ❑ | ❑ | ❑ | ❑ | ❑ |
| 7. Ability to perform tasks involving minimal intellectual effort or repetitive tasks | ❑ | ❑ | ❑ | ❑ | ❑ |
| 8. Ability to perform a variety of tasks at the same time | ❑ | ❑ | ❑ | ❑ | ❑ |
| 9. Ability to follow a regular work schedule | ❑ | ❑ | ❑ | ❑ | ❑ |
| 10. Ability to make decisions | ❑ | ❑ | ❑ | ❑ | ❑ |
| 11. Ability to perform intellectually complex tasks that require high levels of reasoning, math and language skills | ❑ | ❑ | ❑ | ❑ | ❑ |
| 12. Ability to supervise or manage others | ❑ | ❑ | ❑ | ❑ | ❑ |

### Section E – Prognosis

If a return to work has been discussed with the patient, please provide the date and indicate if the return is (DDMM/YYYY)

❑ Part-time ❑ Full-time ❑ Temporary assignment ❑ Light duties ❑ Gradual return to work – Please provide the return-to-work protocol

How long will the patient's leave of absence be?

❑ Less than 3 months ❑ 3 to 6 months ❑ More than 6 months

| Signature | Date (DDJ/MM/YYYY) | |
|---|---|---|
| Name (please print) | Specialty | Licence No. |
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## Hospital statement

**In order for Humania Assurance to properly assess the patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.**

### Section A – Hospital statement

Reason for hospitalization: ______________________

Hospitalization period in the emergency department from ______________ (DD/MM/YYYY) at _____ (hour) to ______________ (DD/MM/YYYY) at _____ (hour)

Hospitalization period in another unit: from ______________ (DD/MM/YYYY) at _____ (hour) to ______________ (DD/MM/YYYY) at _____ (hour)

Specify unit: ______________________

Name of the hospital ______________________

Address ______________________

Date ______________ (DD/MM/YYYY) Signature of the archivist ______________________

**To avoid any delay in the assessment of your claim, please complete and sign all the authorizations below, even if you completed the one found on page 3 of this document.**

## Autorization

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 personal 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 personal information.

| | |
|---|---|
| Name (Please print) | Signature |
| Policy No. | Date (AAA/MM/JJ) |
| | Email Address |

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

4300-013 - Rev. 05/2023

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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 personal information contained on social media or on any Internet platform accessible to the public.

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| | |
|---|---|
| Name (Please print) | Signature |
| Policy No. | Date (AAA/MM/JJ) |
| | Email Address |

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

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## Notes and Comments

**HUMANIA ASSURANCE INC.**

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