



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.
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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 <input type="checkbox"/> Fr. <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name.					
Nature of request for benefits <input type="checkbox"/> Disability <input type="checkbox"/> Waiver of premiums <input type="checkbox"/> 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 duties 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-handed

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 recent, 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/YYYY)	to (DD/MM/YYYY)
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Address (no., street)

Telephone no.	Fax no.	Specialty
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Name	Consulted from (DD/MM/YYYY)	to (DD/MM/YYYY)
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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		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crime victims compensation (IVAC)		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan – Disability		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan – Retirement		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec Pension Plan (QPP) – (RQ) – Disability		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec Pension Plan (QPP) – Retirement		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employment Insurance		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Provincial auto insurance – SAAQ		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Individual insurance		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Group insurance		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Debt or overhead insurance		<input type="checkbox"/>	<input type="checkbox"/>	(DD/MM/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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)			
<input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Temporary assignment <input type="checkbox"/> Light duties <input type="checkbox"/> 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 _____ <i>(If claimant works irregular hours or shifts, provide work schedule.)</i>			
What is the claimant's gross annual salary for the year? \$ _____			
Was the employee <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> On call <input type="checkbox"/> Seasonal <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select one of the following:			
<input type="checkbox"/> Vacation <input type="checkbox"/> Maternity leave <input type="checkbox"/> Employment insurance <input type="checkbox"/> Sick days <input type="checkbox"/> Statutory holidays <input type="checkbox"/> Other _____ <input type="checkbox"/> Employment Insurance caregiving benefits			
Amount \$ _____ From _____ to _____			
Has the claimant submitted a claim to the following government bodies? <input type="checkbox"/> WSIB, CNESST or WCB <input type="checkbox"/> Employment insurance (please attach a copy of the record of employment) <input type="checkbox"/> CPP <input type="checkbox"/> QPP (RQ) <input type="checkbox"/> SAAQ or provincial automobile insurance <input type="checkbox"/> 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. Bending			
5. Climbing up and down stairs			
6. Lifting	0 – 10 pounds <input type="checkbox"/> 10 – 20 pounds <input type="checkbox"/> 20 – 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/> With lifting device? Yes <input type="checkbox"/> No <input type="checkbox"/>		
7. Pushing/Pulling	0 – 10 pounds <input type="checkbox"/> 10 – 20 pounds <input type="checkbox"/> 20 – 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/>		

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 <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ability to attend to personal care (hygiene, meals, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ability to carry out household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ability to relate to co-workers and supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ability to perform work that calls for minimal contact with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ability to understand, carry out and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ability to perform tasks involving minimal intellectual effort or repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ability to perform a variety of tasks at the same time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ability to follow a regular work schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ability to make decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ability to perform intellectually complex tasks that require high levels of reasoning, math and language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Ability to supervise or manage others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.
Address (no., street)			
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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 _____ at _____ (hour) to _____ at _____ (hour)
(DD/MM/YYYY) (DD/MM/YYYY)

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

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.



Authorization

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



Authorization

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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.

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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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HUMANIA ASSURANCE INC.

1555 Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6

Montreal region: 514 489-8404

Saint-Hyacinthe region: 450 773-7170

Other regions: 1 800 773-8404

Web site: www.humania.ca