HUMANIA ASSURANCE MD®

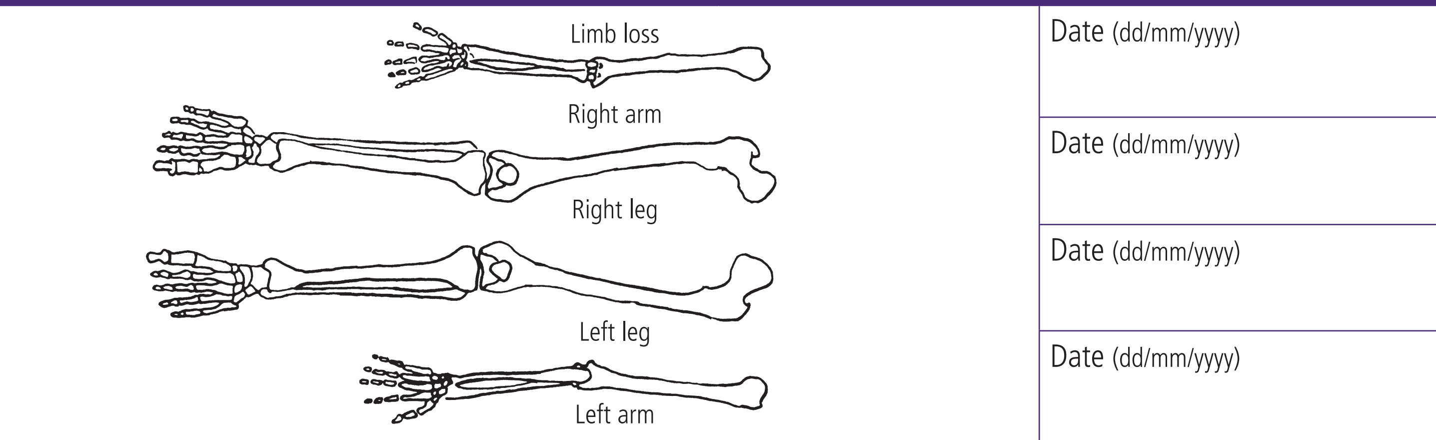
Declaration in case of dismemberment or loss of use

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

Part A - Claimant's information

Policy:	
Las Name:	First Name:
Date of birth (dd/mm/yyyy) :	Social insurance number (SIN):
Address:	
City:	
Province:	Postal Code:
Telephone:	E-mail:
Gender: ❑ Male ❑ Female ❑ Prefer not to respond	Language : ❑ Fr ❑ En

Part B - Please indicate the site of the amputation



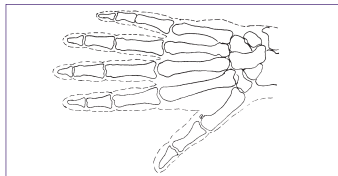
Date (dd/mm/yyyy)

Date (dd/mm/yyyy)

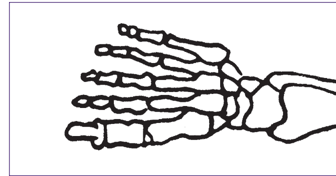
Date (dd/mm/yyyy)

Date (dd/mm/yyyy)

Right hand (dorsal view)



Right foot



It is important to answer every question

1- Provide: a) The date of the accident: (dd/mm/yyyy)	b) The time: At ____________ hours ❑ A.M. ❑ P.M.

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 occured?

4- Provide the details of the acident (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 withesses:

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

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

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

9- Date of 1st treatment by a physician for this incident (dd/mm/yyyy):

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

Part C - 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 and for statistical reporting purposes.

I further authorize Humania Assurance to exchange the personal information collected about me with its Business Partners in Quebec or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

This authorization applies to my past and future personal information held by any individual or corporation including but not limited to any physician, pharmacist or other health professional, any public or private health institution, government agency, provincial health insurance plan, rehabilitation company or employer, the Medical Information Bureau, any investigative agency or law enforcement agency or any insurance or reinsurance company. 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.

❑ I would like to receive the benefit check directly.

❑ I would like that the benefit check be given directly to the broker.

Claimant's name (write in block) Claimant's signature

E-mail Date (dd/mm/yyyy)