HUMANIA ASSURANCE MD®

Claim Form for Critical Illness Insurance Benefit
Claimant statement

For information, please contact us at: Telephone :1-877-987-3076 / Fax: 1-877-660-2519
E-mail: 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:		
Last name:	First name:	
Date of birth (dd/mm/yyyy):	Social insurance number (SIN)	
Address:		
City:	Province:	Postal Code:
Telephone n°:	E-mail:	
Gender: ☐ Male ☐ Female ☐ Prefer not to respond	Language : ☐ Fr ☐ En	
Do you smoke or use tobacco products? ☐ Yes ☐ No If ''Yes", please indicate the quantity per day:		
How long have you smoked or used tobacco products?		
If ''No", did you previously use tobacco products ? ☐ Yes ☐ No On what date did you quit ? (dd/mm/yyyy)		

Part B : Diagnosis

Please describe the nature and extent of your Critical Illness/ Describe the nature and severity of your illness.
Date the Critical Illness was diagnosed or surgery was performed. (dd/mm/yyyy)
Onset date of first symptoms. (dd/mm/yyyy)
Please describe the symptoms that preceded the diagnosis of the disease.
What treatments have you received and are currently receiving, related to your illness (eg : medication, treatments, surgery, etc)?
When did you first consult a physician for the current illness ? Date : (dd/mm/yyyy)

Part B : Diagnosis (continued)		
Please indicate the name and address of the Physician consulted.		
Name of the Physician:		
Address:		
City:	Province:	Postal Code
Telephone n°:	Fax:	
Have you undergone any tests or investigations related to the diagnosis ? If yes, please provide details and dates.		
Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No If yes, please give details including dates.		

Part C : Medical Consultations		
Please provide the name and address of your family physician.		
Name of Physician:		
Address:		
City:	Province:	Postal Code:
Telephone n°	Fax n°:	

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

Name	Address	Telephone	Dates of consultation (dd/mm/yyyy)

Part C : Medical Consultations (continued)

If you have been treated at hopital or similar institution, please supply the following information.

Hospital or establishment	Address	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)

What other treatments have you recevied and are you currently receiving in connection with your condition ?
(eg :medications, therapy, etc.)

Type of treatment	Institution	Prescribing physician	Dates (dd/mm/yyyy)

Part D : General

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

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Part D : General (continued)

Are you insured or receiving 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
		$	☐ Yes ☐ No

Partie E : 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 or 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 personal information of mine 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, including but not limited to the Régie de l'assurance maladie du Québec or rehabilitation company, the Medical Information Bureau or any investigative agency or law enforcement agency or any insurance or reinsurance company. This authorization also applies to any other personal information available on social networks 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 name (write in block) Claimant Signature

_____ _____ _____
Policy Number Date (dd/mm/yyyy)

_____ _____
Applicant's name Relationship with the insured

_____ _____
Applicant's signature Date (dd/mm/yyyy)

_____
E-mail Address

This claim form must be completed by the insured person. If the insured person is unable to do so, the spouse, father, mother, adult beneficiary or legal representative of the insured person can complete the application.