

TRITON INSURANCE COMPANY

1420 - 380 Wellington Street
London, Ontario N6A 5B5

Telephone: 800-285-8623
Fax: 877-772-2623

CLAIMS;10 06

CONTINUING DISABILITY CLAIM FORM

◆ CREDITOR INFORMATION To be completed by the Creditor. ◆

Insured Name: _____ Branch/Account #: _____ Claim #: _____	Branch Mailing Address: _____ _____ Branch Phone Number: _____ Date Received in Branch: _____ (MM/DD/YY)
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◆ FORM COMPLETION INSTRUCTIONS ◆

1. A claim form must be submitted every 30 days for additional benefits to be considered.
2. Fully complete all sections and spaces on the claim form.
3. If a question is not applicable to the claim, a line should be drawn through the space provided for the answer.

NOTE: Altered forms cannot be accepted.

◆ SUBMISSION INSTRUCTIONS ◆

When all required sections are complete, return the claim to the office listed above. Keep a copy of the entire claim form and any attachments for your records. NOTICE: If the form is not fully completed with all attachments, the processing of your claim will be delayed. Please allow 15 days after mailing or faxing for processing fully completed claim forms.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in applicable provincial legislation: In Alberta - *Insurance Act*; In British Columbia, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, Northern Territories and Nunavut - *Insurance Act*; In Manitoba - *The Insurance Act*; In Ontario - *Limitations Act of 2002*; In Saskatchewan and Newfoundland - *The Limitations Act*; In Quebec - *The Civil Code of Quebec*.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Triton Insurance Company collects, uses and discloses personal information about you as described: (1) in the Triton Insurance Company Privacy of Personal Information Statement (a copy of which can be obtained at the address above); (2) in the *Personal Information Authorization* section of this form; and (3) referenced in the creditor insurance application form that relates to your claim. We maintain a file containing your personal information for the purposes outlined in each of the above, accessible at 1420 - 380 Wellington Street, London, Ontario, N6A 5B5. Your file will only be accessible to employees, agents and other authorized representatives of Triton Insurance Company who are responsible for administering your file, and other persons authorized by you or by law.

By signing and submitting this claim form on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor's personal information as described above and elsewhere in this claim form, including the Personal Information Authorization section of this claim form.

Signature: _____ Date: (MM/DD/YY) / /

◆ PERSONAL INFORMATION AUTHORIZATION ◆

I have read and fully understand that contents of the Notice Regarding Collection, Use and Disclosure of Personal Information ("Notice") and acknowledge and consent to Triton Insurance Company collection, use and disclosure of my personal information for the purposes identified in the Notice. For the purposes of claim investigation and processing, I hereby authorize, consent, and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, employer, any workers compensation board, Human Resources and Skills Development or any other organization, institution, association or person identified in the Notice that now has or may in future have any records or knowledge concerning me or my health, employment history, benefits paid or any related information to disclose to Triton Insurance Company, their authorized representatives and reinsurers, upon the request of Triton Insurance Company any such information that is material to the purposes identified in the Notice. A photocopy of this authorization shall be as valid as the original.

Insured or legal representative signature: _____ Date: (MM/DD/YY) / /

If signed by a Personal Representative of the Insured:

Address:	Telephone #:
Printed Name of Personal Representative:	Relationship/Authority to sign for Insured:

In our effort to provide quality service, our Customer Service telephone lines are subject to service monitoring.

Insured Name:	Branch/Account #:
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SECTION I - STATEMENT OF INSURED Print or type all information. To be completed and signed by the insured. All dates *must* include the month, day and year (**MM/DD/YY**).

Date you returned to work: (MM/DD/YY) / /

I certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my information, knowledge and belief.

Signature: Date: (MM/DD/YY) / /

Complete mailing address: City: Province: Postal code:

Telephone #: - -

SECTION II - STATEMENT OF ATTENDING PHYSICIAN To be completed by the Attending Physician. All dates *must* include the month, day and year (**MM/DD/YY**). Any fee for completion of this claim form is the responsibility of the patient.

Our policy defines **total disability** as "a disability caused by an accidental injury or by sickness which continues uninterrupted for 30 or more consecutive days and causes the person insured to be unable to perform any duties of their principal job."

Patient under my care and unable to work due to this disability:
 From: / / Through: / /

Diagnosis and recent surgeries:

Treatments are given how often? Weekly Monthly Other _____ Date last treated: (MM/DD/YY) / /

All treatment dates: (MM/DD/YY)

Approximate date the patient will be able to return to work:
 1-3 months 4-6 months 7 months or longer Never returning

Signature of attending physician: Date: (MM/DD/YY) / /

Complete mailing address: City: Province: Postal code:

Printed name: Telephone #:

SECTION III - STATEMENT OF EMPLOYER To be completed by employer. If self-employed, please state. All dates *must* include the month, day and year (**MM/DD/YY**).

Date last worked: (MM/DD/YY) / /

Is individual still employed? Yes No Date returned to work: (MM/DD/YY) / /

Company name: Telephone #: - -

Complete mailing address: City: Province: Postal code:

Signature of individual completing: Date: (MM/DD/YY) / /

Printed name: Title: