TRITON INSURANCE COMPANY

1420 - 380 Wellington Street
London, Ontario N7A 5B5

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

CLAIMS;10 05

DISABILITY CLAIM FORM

◆ **CREDITOR INFORMATION** To be completed by the Creditor. ◆

Insured Name: _____	Branch Mailing Address: _____ _____
Branch/Account Number: _____	
Was there prior coverage? ☐Yes ☐No If so, provide the branch/account number: _____	Branch Phone Number: _____
	Date Received in Branch: _____ (MM/DD/YY)

◆ **FORM COMPLETION INSTRUCTIONS** ◆

1. Fully complete all sections and spaces on the form.
2. If a question is not applicable, a line should be drawn through the space provided for the answer.
3. Attach a copy of the Loan Protection Insurance Application, the Credit Application and Transaction History.

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 #:**

SECTION I - STATEMENT OF INSURED Print or Type All Information. To be completed, signed and dated by the Insured. All dates *must* include the month, day and year (**MM/DD/YY**).

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

Date of birth: (MM/DD/YY) / /

Date unable to work due to disability: (MM/DD/YY) / /

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

Is this a Worker's Compensation Board case? O Yes O No

If yes, please indicate the W.C.B. # and address.

Is this disability due to an: O Illness O Injury O Accident

Where and how did this disability occur? If accident, also provide date it occurred.

Have you had the same or similar illness or injury before? O Yes O No

If yes, when?

Provide names and addresses of all doctors who have treated you in the past 2 years, and the dates first contacted. If additional space is needed, please attach a separate sheet.

Name of doctor:

Date first contacted: (MM/DD/YY) / /

Doctor's complete mailing address:

City:

Province:

Postal code:

Name of doctor:

Date first contacted: (MM/DD/YY) / /

Doctor's complete mailing address:

City:

Province:

Postal code:

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 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) / /

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

If terminated, date: / /

Company name:

Telephone #: - -

Complete mailing address:

City:

Province:

Postal code:

Signature of individual completing:

Date: (MM/DD/YY) / /

Printed name:

Title:

Insured Name:	Branch/Account #:

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

Primary diagnosis:

Contributing cause/complications of disability:

Surgical procedures and dates and/or hospital confinement dates: (MM/DD/YY)

If pregnancy related, provide the estimated date of delivery and list any complications:

If hospitalized, provide dates: (MM/DD/YY)
From: / / Through: / /

Patient unable to work due to this disability: (MM/DD/YY)
From: / / Through: / /

Initial date of treatment: (MM/DD/YY) / /

All subsequent treatment dates: (MM/DD/YY)

Frequency of visits: O Weekly O Monthly O Other The disability is due to: O Injury O Illness O Accident

When did symptoms first appear or accident occur? (MM/DD/YY) / /

Has the patient ever had the same or similar illness or injury before? O Yes O No If yes, when? (MM/DD/YY)

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

Was there a referring physician? O Yes O No

Referring physician's name: Date of referral: (MM/DD/YY) / /

Referring physician's address: City: Province: Postal code:

Printed name of attending physician: Telephone #: - -

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

Complete mailing address: City: Province: Postal code: