CHUBB

CLAIMANT'S STATEMENT OF DISABILITY

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

TO BE FULLY COMPLETED BY CLAIMANT
PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No.:		
Claimant's Full Name:	**Phone #: ( )**	**Cell #: ( )**
Social Insurance Number (required for taxable benefits):		
Address:		
City:	**Province:**	**Postal Code:**
Email Address (if you wish to correspond by email):		
Date of Birth:	☐ **Male** ☐ **Female**	
Date of Accident/Injury:		
Did Accident happen at work? ☐ Yes ☐ No If "Yes", how did it happen? Provide a brief description:		
Date you were first unable to work because of this disability.		☐ **AM** ☐ **PM**
Have you returned to work? ☐ Yes ☐ No If "Yes", provide date returned.		☐ **AM** ☐ **PM**
Date of first medical attendance:		
Name of Attending Physician(s):		
Address of Attending Physician(s):	**Phone #: ( )**	**Fax #: ( )**
If hospitalized, name of Hospital:		
Hospitalized: From:	**To:**	
Are you receiving any other insurance benefits as a result of this accident/sickness?		
☐ **W.C.B./W.S.I.B. $**	☐ **C.P.P./Q.P.P. $**	☐ **AUTO INS $**
☐ **Employer Disability $**	☐ **Other: $**	

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

Authorization: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Signature of Claimant _____ Date _____

PROVIDING THIS FORM DOES NOT GUARANTEE PAYMENT OF BENEFITS.
SEE ATTENDING PHYSICIAN STATEMENT OF DISABILITY FORM.