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INSTRUCTIONS FOR FILING A SICKNESS CLAIM

We are very sorry to hear about your loss and we wish you a speedy recovery.
To avoid delays, please answer all applicable questions on the claim form and attach any medical information that you may have on hand.

CLAIMANT'S STATEMENT
TO BE COMPLETED BY THE CLAIMANT

Please be sure to give us your complete name and address. Your payment and/or any correspondence will be mailed to the address on the claim form unless we are directed to do so otherwise.

Write down all policy numbers including those where you are a dependent.

If filing for loss due to sickness, fill in the first section of the form relating to your symptoms and diagnosis.

Please provide any reports to substantiate your diagnosis i.e.: outpatient surgery, MRI report, pathology etc.

If hospitalized, please have the hospitalization form fully completed and signed by the Health Records Department. If you were hospitalized in more than one hospital, please provide a confirmation from each hospital. The confirmation must contain:

- The admittance and discharge dates
- The unit or section in which you were hospitalized
- The hospital seal of the records department

If you are claiming for disability, please indicate the exact dates of partial and/or total disability.

If gainfully employed outside the home, the employer may be required to confirm your absence for disability.

If you are self-employed give us the nature of your occupation.

Please be sure to sign and date the authorization section located near the top of the form to enable us to obtain additional information, if necessary. This will save processing time in the event that additional information is needed.

ATTENDING PHYSICIAN'S STATEMENT
TO BE COMPLETED BY YOUR TREATING PHYSICIAN

For a sickness claim, the primary physician must complete the form, providing the diagnosis, how the condition originated, and the dates of treatment. If treated as an outpatient we need the service date. If treated as inpatient, you must provide confirmation of hospitalization from the Health Records Department of the hospital(s) attended.

Disability dates, both total and partial, must be indicated by the doctor. Please provide the doctor's complete address and phone number.

For your records, we suggest that you make a copy of both sides of the claim form and of any bill(s) you submit. Note the date mailed. Mail the completed form and any enclosures to:

COMBINED INSURANCE COMPANY OF AMERICA
CLAIMS DEPARTMENT
P.O.BOX 3720 MIP
MARKHAM, ON L3R 0X5
Toll free number: 1-888-234-4466
Fax: 905-754-4362

For faster processing, we encourage you to visit our self service portal at www.combined.ca to file your claim and upload applicable documents.

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CANADIAN HEAD OFFICE P.O. BOX 3720 MIP, MARKHAM, ON L3R 0X5
TELEPHONE: 1 888 234-4466 • FAX: 1 905 754-4362 • www.combined.ca

This form must be fully completed and returned within 90 days of the loss
Did you know you can file a claim online for faster service? Visit our website at www.combined.ca
In an effort to avoid a delay in the processing of your claim, please complete the form in its entirety, paying special attention to fields in bold.

SICKNESS CLAIM FORM

IMPORTANT: Review your claim form. Is it complete? A form not fully completed may delay the processing of your claim. Also retain a copy of both sides of your completed claim form.

I consent and authorize Combined Canada to access, collect, retain, disclose, and exchange Personal Information. I understand that this consent will remain in place until such time as I revoke it. This consent and associated Personal Information will be managed according to the Combined Canada Privacy Policy published on:

https://www.combinedinsurance.com/ca-en/

I understand that the Personal Information will be used to investigate, assess, and administer any application(s) or claim(s) I make. I affirm that all information I provide is true and I acknowledge that insurance fraud is illegal. Personal Information may be exchanged with any insurance company, healthcare provider, benefits administrator, MIB (Medical Information Bureau), provincial health care plan or other parties with knowledge of me or my health, located within or outside Canada, when relevant to investigating, assessing, and administering my application(s) and my claim(s). This Personal Information may be shared electronically, by phone, or in paper format and all exchanges of information will adhere to applicable privacy laws.

I understand I can request access to or correction of my Personal Information. For more details on my privacy rights, I can refer to the Privacy Policy linked above.

☐ **Check this box if you are providing consent on behalf of another person.** (Additional documentation required)

Signature of insured	Date (MM/DD/YYYY)

CLAIMANT'S STATEMENT

NAME OF INSURED LAST NAME	GIVEN NAME		HOME PHONE CELL PHONE	
MAILING ADDRESS STREET		APT. #	PREFERRED METHOD OF CONTACT MAIL ☐ EMAIL ☐	POLICY NUMBER(S) a)
CITY	PROVINCE	POSTAL CODE	EMAIL	b)
BIRTHDATE MM DD YYYY	AGE	SEX M ☐ F ☐	The email address provided will be used to communicate with you regarding your Combined Insurance claims only, and not for marketing and/or promotional reasons of any kind.	c)

ALTERNATE CONTACT INFORMATION

LAST NAME	FIRST NAME	RELATIONSHIP TO INSURED
HOME PHONE	CELL PHONE	EMAIL

If insured is a minor, please provide the name of a legal guardian/parent who resides with child. Provide any relevant documentation (custody order or legal guardianship), if applicable.

Address of legal guardian if different from minor

COMPLETE FOR SICKNESS

Date of first symptoms **(MM/DD/YYYY)**	Have you ever had same or sim If "Yes", give date **(MM/DD/YY)** **Yes** **Date**
Nature of sickness	

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This form must be fully completed and returned within 90 days of the loss

PLEASE PRINT

IMPORTANT: Review your claim form. Is it complete? A form not fully completed may delay the processing of your claim. Also retain a copy of both sides of your completed claim form.

CLAIMANT'S STATEMENT

COMPLETE IF YOU ARE EMPLOYED OR SELF EMPLOYED

Occupation/Job title

Name of your business or employer

Job description

COMPLETE IF YOU ARE UNEMPLOYED OR RETIRED OR IF CLAIM IS FOR A CHILD

Describe your usual daily activities prior to the onset of your sickness

COMPLETE FOR SICKNESS

This section is mandatory if you are claiming disability

Date that you first sought medical care for this condition?
(MM/DD/YYYY)

Were you disabled at any time following your sickness? If yes, complete the following questions:

Dates during which you were unable to perform all the duties pertaining to your usual occupation or perform your usual daily activities, if not employed

First day of total disability: **(MM/DD/YYYY)**

Last day of total disability: **(MM/DD/YYYY)**

Dates during which you were able to perform part of the duties pertaining to your usual occupation or perform part of your usual daily activities, if not employed.

First day of partial disability: **(MM/DD/YYYY)**

Last day of partial disability: **(MM/DD/YYYY)**

Are you still totally disabled? Yes ☐ No ☐

Your family doctor's name and address	Hospital name and address	Date of confinement **(MM/DD/YYYY)**
		- Admission date: - Discharge date: - Emergency Room: - Arrival time: - Departure time:

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ATTENDING PHYSICIAN'S STATEMENT

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The patient is responsible for securing this form and for charges incurred for its completion.

Name of patient: Date of birth: (MM/DD/YYYY)

1. Diagnosis of present condition (specific medical diagnosis)
   (a) Primary Diagnosis _____
   (b) Additional conditions or complications _____
   (c) Objective findings (including results of x-rays, laboratory data or any other special tests). Attach all test results/specialist reports. _____
   _____
2. If condition is due to pregnancy, what is the expected delivery date? _____
3. **Sickness** – Date symptoms first appeared (MM/DD/YYYY) _____
   Has patient ever had same or similar condition? Yes ☐ If "Yes", state when and describe under section 11.
   No ☐
4. (a) If patient was referred to you, give complete name of referring physician _____
   (b) If you have referred patient to a specialist, give complete name(s) of physician(s) _____
   _____
   (c) Has the patient been referred for physiotherapy? Yes ☐ No ☐
   (d) Please list any prescribed medical appliances _____
   _____
5. (a) Date patient first consulted for present condition (MM/DD/YYYY) _____
   (b) Date of last visit (MM/DD/YYYY) _____
   (c) Were you actively supervising patient's care during full period?
   Yes ☐ Frequency: weekly ☐ monthly ☐ Other (Specify) _____
   No ☐ If "No", please comment under section 11.
6. Name of hospital where treated _____
   (a) Emergency Room – Arrival Date and Time (MM/DD/YYYY) _____ Departure Date and Time (MM/DD/YYYY) _____
   (b) Inpatient Hospital Confinement – Admission Date (MM/DD/YYYY) _____ Discharge Date (MM/DD/YYYY) _____
   (c) Outpatient Surgery - Date (MM/DD/YYYY) _____
7. Nature of Treatment (e.g. date and type of surgery, including medication)_____
   _____
8. What is your patient's occupation?
   _____
9. To the best of my knowledge,
   (a) The patient has been **totally** disabled (unable to work or perform daily activities) from _____ to _____ inclusive.
   (b) The patient has been **partially** disabled (able to perform some duties at work or some daily activities) from _____ to _____ inclusive.
   (c) What are the restrictions and limitations preventing patient from returning to work or doing daily activities?_____
   _____
   If still unable to work or perform daily activities, give approximate date when patient should be able to return to work or perform daily activities.
   _____
10. If patient is a student, what are the restrictions and limitations affecting his/her daily activities? _____
    _____
11. Please provide any other information that would be helpful in the assessment of your patient's claim _____
    _____
    _____

Name of attending physician (please print) _____ Specialty _____

Address _____ Telephone _____

Signature _____ Date_____

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P.O. BOX 3720 MIP, MARKHAM, ON L3R 0X5
TELEPHONE: 1 888 234-4466 • FAX: 1 905 754-4362 • www.combined.ca

Authorization to disclose information to my Insurance Agent

IMPORTANT: Completing this form is optional and is not required as part of the application/claim process. When this form is completed and signed, Combined Insurance Company of America ("Combined Insurance") is given authorization to provide the identified insurance agent (and agency if applicable) the information specified below in addition to what Combined Insurance might ordinarily provide the insurance agent (and agency if applicable).

Customer Information

First Name	Middle Name	Last Name	DOB MM/DD/YY

Address	Policy number(s) Please list at least one policy number

The customer identified above is the ☐ Insured Covered under the Policy ☐ Policy Owner

Insurance Agent Information

First Name	Last Name	Agent Code

Address

Agency (if applicable)

Agency Name	Agency Address

Customer Authorization and Signature

I authorize Combined Insurance to disclose the following information to my insurance agent (and agency if applicable):

☐ Underwriting information including medical information related to an underwriting decision, limited to the policy number(s) identified below

☐ Claim information including medical information related to a claim decision, limited to the claim number(s) identified below.

Policy Number(s)
Claim Number(s)

I understand that Combined Insurance reserves the right to limit the information that will be shared with my insurance agent (and agency if applicable). I may withdraw this authorization at any time by sending a signed request to Combined Insurance. On receipt and processing of my withdrawal request, no further information beyond what would normally be shared will be provided to my insurance agent.
I agree that a copy of this authorization is as valid as the original. This authorization is limited to the underwriting and/or claim information identified above and is valid for six (6) months after the date of signing this authorization or until the closure of the underwriting and/or claim file, whichever is longer.

Customer Signature	**Date MM/DD/YY**
Print name of parent or guardian signing (if applicable)	**Relationship (if applicable)**

This authorization will become effective on the date it is received by Combined Insurance Canadian Head Office at the following address:

COMBINED INSURANCE COMPANY OF AMERICA
Canadian Head Office: Claims Department
P.O. BOX 3720 MIP, MARKHAM, ON L3R 0X5

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CONSENT TO ELECTRONIC TRANSACTIONS, PAYMENTS AND SIGNATURE

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America ("Combined"), of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at https://my.combinedinsurance.com or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department, Monday through Friday between 8:00 am and 7:00 pm EST, or go to www.combinedinsurance.com/ca-en/contact-us to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a chequing account or transfer into a PayPal account. Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a cheque mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

_____ _____

Print Name **Signature**

_____ _____

E-mail Address **Date**