CHUBB

PROOF OF LOSS / DISMEMBERMENT CLAIM
ATTENDING PHYSICIAN'S STATEMENT

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

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

First Name of Patient:	Last Name of Patient:	Date of Birth:

HISTORY

a) When did symptoms first appear or accident happen?	
b) Date patient ceased work because of disability:	
c) Has patient ever had same or similar condition: ☐ Yes (state when & describe) ☐ No ☐ Unknown	
d) Is condition due to injury or sickness arising out of employment? ☐ Yes ☐ No	
e) Names of any other treating Physicians:	**Address:**
Names of any other treating Physicians:	**Address:**

DIAGNOSIS, NATURE OF LOSS

a) Primary (if fracture or dislocation, state whether complete or incomplete)
b) Secondary (if applicable)
c) Did any disease or previous injury contribute to the loss? Please provide details:
d) Is loss permanent and irrecoverable? Please provide details:

TREATMENT

a) Date of First Visit:	
b) Date of Latest Visit:	
c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify):	
d) Date of Hospitalization: Confined From:	**To:**
Hospital Name:	
e) Nature of Treatment (including medication, therapy and surgery, if any)	

PHYSICAL IMPAIRMENT

Degree of Limitation of Functional Capacity:
☐ Class 1 – No Limitation: Capable of heavy work. No Limitations. (0-10%)
☐ Class 2 – Significant Limitation: Capable of light manual activity. (15-30%)
☐ Class 3 – Moderate Limitation: Capable of Clerical/Administrator (sedentary) activity. (35-55%)
☐ Class 4 – Marked Limitation. (60-70%)
☐ Class 5 – Severe Limitation: Incapable of minimal (sedentary) activity. (75-100%)
Remarks:

VISUAL (IF APPLICABLE)

(For loss of vision due to accident only)			
What was vision at latest observation?	**With glasses:**	**O.D.**	**O.S.**
	Without glasses:	**O.D.**	**O.S.**
Vision can be restored in whole or part by:	**O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable**		
	O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable		

REMARKS

Name of Attending Physician:	**Degree:**	
Phone #: ( )	**Fax #: ( )**	
Address:		
City:	**Province:**	**Postal Code:**

Signature_____ Date _____

PLEASE NOTE THAT ALL CHARGES FOR THE COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE CLAIMANT