



**PROOF OF LOSS
DISMEMBERMENT CLAIM
CLAIMANT'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

THIS SECTION TO BE COMPLETED BY THE CLAIMANT

Policy No.:		
Claimant's Name:		Phone #: ()
Full Mailing Address:		
City:	Province:	Postal Code:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Name of Current Employer:	Occupation:	
Employer's Address:		
Date and Time when Accident Occurred:		Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Where did the accident happen?		
How did the accident occur? (describe fully)		
What injuries were incurred as a result of this accident?		
Name and Addresses of all Doctors consulted (Attach a separate list if necessary)		
1.		
1 st treatment Date:		
2.		
1 st treatment Date:		
3.		
1 st treatment Date:		
Were you hospitalized as a result of this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name and Address of Hospital:		
From:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	
To:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Are you receiving any other insurance benefits as a result of this accident?		
<input type="checkbox"/> W.C.B./W.S.I.B. <input type="checkbox"/> C.P.P./Q.P.P. <input type="checkbox"/> Employer Disability <input type="checkbox"/> Automobile Ins. <input type="checkbox"/> Other:		
Company:	Benefit Type:	Amount:

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.

Claimant's Signature _____ Date _____