ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

PROOF OF LOSS
DISMEMBERMENT CLAIM
CLAIMANT STATEMENT

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 ☐M ☐F	Date of Birth	
Name of Current Employer	Occupation	
Employer's Address		
Date and Time when accident occurred	Time: ☐a.m. ☐p.m.	
Where did the accident happen?		
How did the accident occur? (describe fully)		
What injuries were incurred as a result of this accident?		
Names and Addresses of all Doctors consulted (Attach a separate list if necessary)		
1		
1st Treatment Date		
2		
1st Treatment Date		
3		
1st Treatment Date		
Were you hospitalized as a result of this accident? ☐Yes ☐ No If Yes, Name and Address of Hospital		
From	Time: ☐a.m. ☐p.m.	
To	Time: ☐a.m. ☐p.m.	
Are you receiving any other insurance benefits as a result of this accident? ☐ W.C.B. / W.S.I.B. ☐ C.P.P./Q.P.P. ☐ Employer Disability ☐ Automobile Ins. ☐ Other		
Company	Benefit Type	Amount

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CLAIMANTS 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 ACE INA Insurance and/or ACE INA 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 I may authorize.

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 ACE INA Insurance/ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about me or any other information or records about me in its possession that is requested while administering my claim.

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

Claimant' Signature _____ Date _____