



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/DISEMBLEMENT CLAIM
 ATTENDING PHYSICIAN'S STATEMENT**

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

First name of patient	Last Name of patient	Date of Birth
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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? <input type="checkbox"/> Yes (state when & describe) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
d) Is condition due to injury or sickness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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
<input type="checkbox"/> Class 1 – No limitation: Capable of heavy work. No Limitations. (0-10%)
<input type="checkbox"/> Class 2 – Slight limitation: Capable of light manual activity. (15%-30%)
<input type="checkbox"/> Class 3 – Moderate limitation: Capable of Clerical/Administrative (sedentary) activity. (35-55%)
<input type="checkbox"/> Class 4 – Marked limitation. (60-70%)
<input type="checkbox"/> Class 5 – Severe limitation: Incapable of minimal (sedentary) activity. (75-100%)
Remarks



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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.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment
		<input type="checkbox"/> Operation	<input type="checkbox"/> Not Restorable
	O.S.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment
		<input type="checkbox"/> Operation	<input type="checkbox"/> Not Restorable

Remarks

Name of attending Physician	Degree
Phone # ()	Fax # ()
Address	

Signature _____

Date _____

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