Assumption Life

Reset

Total Disability
Claimant's Statement

A. Identification

Name of Insured: _____

Policy Number(s): _____ Date of Birth (DD/MM/YYYY): _____

Address: _____

Telephone: Home _____ Cell._____Work _____

B. General Information

1. Occupation at the time of present disability: _____
2. Are you self-employed? ☐ Yes ☐ No
3. Name and address of employer: _____
   _____
4. Annual salary at time of disability:_____
5. Education: _____ Training: _____
6. Previous work experience: _____
   _____
7. Are you currently using any form of tobacco or nicotine? ☐ Yes, since when? _____ Which form? _____
   ☐ No, date ceased: _____
   ☐ Never used any form of tobacco
8. Name and address of your regular attending physician:_____
   _____
9. Describe injuries or illnesses prior to the present disability. Please provide dates, names and addresses of the treating physicians.
   _____
   _____
   _____

C. Information about your disability:

1. Nature of your current disability: _____
2. Date of earliest symptoms: _____
3. Description of symptoms: _____
   _____
   _____
4. If the current disability is the result of a work-related accident, provide a description of the event along with the name and address of your case manager:_____
   _____
   _____
   _____
5. If the disability is related to another type of accident, please describe and include a police report if applicable:_____
   _____
   _____
   _____
6. As of what date did your medical condition prevent you from working on a continuous basis? _____
   DD/MM/YYYY
7. Have you been continuously disabled until now? ☐ Yes ☐ No , please explain: _____
   _____
   _____
   _____
8. Date of the first medical consultation for this disability: (DD/MM/YYYY)_____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

9. Provide name of all physicians who treated you during this disability:

Date of consultation	Doctor's name	City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. If you were hospitalized or treated in another medical establishment (ex. medical clinic, emergency dept.), please provide the following details:

Name of hospital or clinic	City	Date of consultation or admission
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Describe your current state of health and provide reasons to support total disability: _____
_____
_____
_____

12. Date you returned to or expect to return to work. _____
DD/MM/YYYY

D. Income from other sources

1. Have you applied or will you be applying for benefits from any of the following sources?

Employment Insurance	☐ No	☐ Yes	Monthly benefits: $ _____
Worker's Compensation or similar plan	☐ No	☐ Yes	Monthly benefits: $ _____
Canada/Quebec pension plan	☐ No	☐ Yes	Monthly benefits: $ _____
Automobile insurance	☐ No	☐ Yes	Monthly benefits: $ _____
Group insurance plan provided by your employer	☐ No	☐ Yes	Monthly benefits: $ _____

List all other insurance policies that provide benefits at time of disability:

Life Insurance Company	Amount of Monthly Benefits	Policy Issue Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. For benefits from disability insurance based on a loan: Is this loan insured with another insurance carrier?

☐ No ☐ Yes- Name of insurer and amount of monthly benefits: _____
_____
_____
_____

Declaration and authorization

I, authorize Assumption Life, in the assessment of my claim, to obtain the necessary information from individuals or organizations holding personal information about me, including other insurance companies, financial institutions, physicians, medical institutions and healthcare providers, employers or group insurance plan administrators, agents, representatives or brokers and all persons or organizations who may have personal information regarding my claim.

Furthermore, I authorize Assumption Life to provide necessary personal information about me to the abovementioned individuals and organizations or to exchange this information with them

I confirm that a photocopy or electronic version of this authorization has the same value as the original.

_____ _____
Date (DD/MM/YYY) Claimant's Signature

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