

Total Disability Claimant's Statement

A. Identification Name of Insured: Policy Number(s): _____ Date of Birth (DD/MM/YYYY): ____ _____Cell._______Work______ Telephone: Home **General Information** Occupation at the time of present disability: 1. 2. Are you self-employed? ☐ Yes ☐ No 3. Name and address of employer: Annual salary at time of disability:_____ 4 _____Training: _____ 5. Education: _____ Previous work experience: 6. No, date ceased: ☐ Never used any form of tobacco 8. Name and address of your regular attending physician:____ Describe injuries or illnesses prior to the present disability. Please provide dates, names and addresses of the treating physicians. 9. Information about your disability: Nature of your current disability: ______ 1. 2. Date of earliest symptoms: ______ 3. Description of symptoms: _____ 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:_____ If the disability is related to another type of accident, please describe and include a police report if applicable: As of what date did your medical condition prevent you from working on a continuous basis? _____ Have you been continuously disabled until now? ☐ Yes ☐ No , please explain: 7. Date of the first medical consultation for this disability: (DD/MM/YYYY)

	9.	Provide name of all physicians who ti	eated you during this disabilit	ıy.	
		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 visus aurent that of health			
	11.	1. Describe your current state of health and provide reasons to support total disability:			
	12. Date you returned to or expect to return to work				VANA DODOV
D.	Income from other sources				//MINI/YYYY
	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 place Canada/Quebec pension plan	an	☐ No ☐ Yes ☐ No ☐ Yes	Monthly benefits: \$ Monthly benefits: \$
		Automobile insurance		No Yes	Monthly benefits: \$
		Group insurance plan provided by yo	ur employer	☐ No ☐ Yes	Monthly benefits: \$
		List all other insurance policies that provide benefits at time of disability:			
		Life Insurance Company	Amount of Mont	hly Benefits	Policy Issue Date
	2.	For hanefits from disability insurance	hased on a loan: Is this loan i	nsured with another insur	rance carrier?
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 a	uthorization	
infor emp	rmati loye	ion about me, including other insur rs or group insurance plan administra	ance companies, financial in	stitutions, physicians, me	individuals or organizations holding persona edical institutions and healthcare providers ons or organizations who may have persona
		ion regarding my claim. nore, I authorize Assumption Life t	o provide necessary persor	nal information about m	e to the abovementioned individuals and
		tions or to exchange this information v			
con	ıfirm	that a photocopy or electronic version	on of this authorization has th	ne same value as the origi	nal.
Date (DD/MM/YYY)			Claimant's Signature		

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