



GROUP INSURANCE

## **DISABILITY CLAIM FORM**

Initial assessment

*In order to ensure confidentiality of personal information, Humania Assurance will establish a claim file in which information concerning all of your claims will be kept. Only employees or authorized agents of Humania Assurance responsible for the management of your claim shall have access to the file.*

**Instructions for:**

- A. The claimant
1. Please complete and sign the "Claimant statement" section.
  2. Please ensure that the policyholder completes and signs the "Policyholder statement" section.
  3. Please ensure that your physician completes and signs the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other condition. As well, please provide your physician with a copy of your completed "Claimant statement" so that the physician will have your signed authorization to release information to Humania Assurance.
  4. Please note that any costs incurred for the completion of the "Attending physician statement" are your responsibility.
  5. Please ensure that all of the above-mentioned forms are submitted to Humania Assurance on a timely basis. Submitting them together will avoid unnecessary delays in the assessment of your claim. Also, please enclose a copy of the first and/or last unemployment cheque stub and the record of employment form if applicable.
- Direct deposit
6. Please complete and sign the direct deposit authorization at the bottom of this page if you are not already using direct deposit with Humania Assurance. The form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.
- B. The policyholder
1. Please complete and sign the "Policyholder statement" section.
  2. In order to avoid unnecessary delays in the processing of Long-Term Disability claims (without Short-Term Disability), we ask that these forms be completed and sent to Humania Assurance as follows:  
 For policies with an elimination period of:
    - 15 weeks, completed forms should be sent to us as of the 8<sup>th</sup> week of absence;
    - 17 weeks, completed forms should be sent to us as of the 11<sup>th</sup> week of absence;
    - 26 weeks, completed forms should be sent to us as of the 20<sup>th</sup> week of absence.
- C. The physician
1. Please complete and sign the appropriate "Attending physician statement", depending on the nature of the primary diagnosis.

**Direct deposit – Authorization**
 Initial request for direct deposit                       Request for bank account change                       Request to end direct deposit

**I Insured statement (please print)**

Policy and sub-group no.	Certificate no.	Insured surname	Given name(s)
Telephone no. (day)	Main residence address (no., street)		Apt.
City	Province	Postal code	
Financial institution name	Financial institution address		

**II Type of bank account (please print)**
 Chequing     Savings    Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

Branch no. (5 digit number)						Institution no. (3 – 4 digit number)					Account no. (All numbers)
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**III Authorization**

I authorize Humania Assurance to credit all my benefit payments to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Humania Assurance of any subsequent changes. I accept that this agreement may be cancelled at any time by either Humania Assurance, myself, in writing or verbally.

Insured signature	Date	(YYYY/MM/DD)
Account holder signature (if other than Insured)	Date	(YYYY/MM/DD)

For information, please contact us at: in the Montreal region at 514 485-7236, in the Saint-Hyacinthe region at 450 773-7236, elsewhere at 1 800 818-7236.  
**Our address is: P.O. Box 10 000 at Saint-Hyacinthe (Quebec) J2S 7C8 • Web site: [www.humania.ca](http://www.humania.ca)**

### Claimant statement

To be completed by the claimant. All questions must be answered in as much detail as possible.

#### Section A – General information

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (YYYY/MM/DD)	Policy no.	Certificate no.
Surname		Given name(s)		Social insurance number
Address (no., street)				
City	Province	Postal code	Telephone no.	Language <input type="checkbox"/> Fr. <input type="checkbox"/> En.
Name of employer (and division if different)		Occupation (just prior to last day worked)		Original date of hire (YYYY/MM/DD)
Other current employer <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name.				
Nature of request for benefits <input type="checkbox"/> Short-Term Disability (Please enclose a copy of the record of employment form, if applicable) <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Waiver of premiums				

#### Section B – Claim information

Was the reason you stopped working due to  
 Illness  Injury away from work  Motor vehicle accident (not while working)  Occupational illness or work accident  
*(If the reason was a motor vehicle accident, please submit a police or collision report, except in Quebec.)*

**If you have suffered an injury, please describe how, when, and where the injury occurred.**

Last day worked (YYYY/MM/DD)	
Were you performing <input type="checkbox"/> Your regular duties <input type="checkbox"/> Modified duties	
Was this a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, how many hours did you work on your last day?
Date you were first unable to work (YYYY/MM/DD)	When did you first notice these symptoms? (YYYY/MM/DD)
When were you first treated by a physician for this condition? (YYYY/MM/DD)	
Please describe all of your symptoms, including frequency and severity.	
Have you ever had the same or similar illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the dates and name(s) of physicians who treated you at the time.	
Please describe the major duties of your occupation.	
Please describe why you are unable to perform the duties of your occupation.	
Please indicate if you are <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed	
Do you have an expected date of return to work? <input type="checkbox"/> If yes, please provide the date (YYYY/MM/DD) <input type="checkbox"/> No	

**Claimant statement (continued)**

**Section C – Health care professionals information**

Please list all of the health care professionals you have consulted **in the last 12 months**, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name		Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)	
Address (no., street)			
Telephone no.	Fax no.	Specialty	
Name		Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)	
Address (no., street)			
Telephone no.	Fax no.	Specialty	
Name		Consulted from (YYYY/MM/DD) to (YYYY/MM/DD)	
Address (no., street)			
Telephone no.	Fax no.	Specialty	

**Section D – Other income information**

If you have applied for, or are receiving any income from any of the following sources, please complete the appropriate section below and submit a copy of your notice of acceptance or refusal, if applicable.

Source	Claim no., contact name, telephone no.	Have you applied?		Are you receiving payment?			Monthly Amount
		Yes	No	Yes	No	Pending	
Worker's Comp – CSST, WSIB, WCB		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crime victims compensation (IVAC)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan – Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada Pension Plan – Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec Pension Plan (QPP) – Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec Pension Plan (QPP) – Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employment Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Provincial auto insurance – SAAQ		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other insurer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Section E – Claimant authorization and declaration**

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance, all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance Inc., to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Humania Assurance, will use the information provided in this form and any prior claims under the same plan for the management of my claim and for production of statistical reports.

I certify that the information contained in this form is true and complete.

**This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.**

Name (please print)	Signature
Policy no.	Date (YYYY/MM/DD)

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**Policyholder statement**

**To be completed by the policyholder. All questions must be answered in as much detail as possible.**

**Section A – Policyholder information**

Name of policyholder (Employer/Union/Association)		Name of subsidiary or division (if different)	
Address (no., street)			
City	Province	Postal code	Telephone no.

**Section B – Claimant information**

Surname		Given name(s)	
Policy no.	Division no.	Class no.	Social insurance number
Certificate no.		Permanent employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature of request for benefits		<input type="checkbox"/> Short-Term Disability (please enclose a copy of the record of employment form, if applicable) <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Waiver of premiums	
Please provide the date on which this claimant was first covered under this policy.			(YYYY/MM/DD)
Was the employee actively at work when the absence began/loss occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please comment.			
What was the claimant's date of hire? (YYYY/MM/DD)		Last date of work? (YYYY/MM/DD)	Forseen return to work date? (YYYY/MM/DD)
If already back at work, what was the start date? (YYYY/MM/DD)			
<input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Temporary assignment <input type="checkbox"/> Light duties <input type="checkbox"/> Gradual – Please provide the return to work protocol			
What was the claimant's main reason for the absence?			
<input type="checkbox"/> Illness <input type="checkbox"/> Injury away from work <input type="checkbox"/> Motor vehicle accident (not while working) <input type="checkbox"/> Occupational illness or work related accident			
Please indicate the hours of work in a normal work week.			
Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____ <i>(If shift work, please provide work schedule.)</i>			
What was the claimant's gross weekly salary as of his/her last day of work? \$ _____			
Was the claimant <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> On call			
Did the claimant receive any income during the disability period? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please select one of the following:			
<input type="checkbox"/> Employment insurance (please enclose a copy of the record of employment form)		<input type="checkbox"/> Vacation <input type="checkbox"/> Maternity leave <input type="checkbox"/> Sick days <input type="checkbox"/> Statutory holidays <input type="checkbox"/> Other _____	
Amount \$ _____		From _____ (YYYY/MM/DD) to _____ (YYYY/MM/DD)	
Has the claimant submitted a claim to the following government bodies?			
<input type="checkbox"/> WSIB/WCB/CSST <input type="checkbox"/> Employment insurance (Please enclose a copy of the record of employment form)		<input type="checkbox"/> CPP <input type="checkbox"/> QPP (RRQ)	
<input type="checkbox"/> SAAQ – Provincial automobile insurance board		<input type="checkbox"/> Crime Victim Compensation Act	

**Policyholder statement (continued)**
**Section C – Occupational information**

What was the claimant's regular occupation immediately prior to his/her stopping work?

 Were the claimant's duties modified from his/her regular occupation?  Yes  No

Please describe this employee's regular occupation (or attach a copy of the job description) as well as any modifications.

The following physical demands analysis of the claimant's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

- I) at any one time without a break (approximately) and;
- 
- II) in total throughout the day (approximately)

**Physical demands analysis**

		I	II
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down the stairs			
6. Lifting	0 – 10 pounds <input type="checkbox"/> 10 – 20 pounds <input type="checkbox"/> 20 – 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/> with lifting device?    Yes <input type="checkbox"/> No <input type="checkbox"/>		
7. Pushing/Pulling	0 – 10 pounds <input type="checkbox"/> 10 – 20 pounds <input type="checkbox"/> 20 – 50 pounds <input type="checkbox"/> 50 pounds + <input type="checkbox"/>		

Please describe work environment (i.e.: temperature, noise levels, chemical/dust exposure, etc.).

Does the claimant wear personal protective equipment (i.e.: safety glasses/footwear, respiratory protection, ear protection, etc.)? If yes, please describe.

 Is there any circumstances or facts that would cause you to question the validity of the claim?  Yes  No If yes, please explain.

I certify that the information given above is true and complete.

Date (YYYY/MM/DD)

Name (please print)

Telephone no.

Signature of the authorized person

Job title

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### Attending physician statement – physical conditions

In order for Humania Assurance to properly assess your patient's claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

#### Section A – Information about the patient

Surname		Given name(s)	
Date of birth	(YYYY/MM/DD)	Height	Weight

#### Section B – Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or date accident occurred? (YYYY/MM/DD)

What was the date of the patient's first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient's first visit as regards to the present disability period? (YYYY/MM/DD)

According to the anamnesis and your clinical exam, is your patient's condition the result of an accidental event  Yes  No Please elaborate:

If your patient has an orthopaedic and/or musculo-skeletal condition, has an X-ray, MRI, or any other tests been performed?  Yes  No If yes, please attach a copy of the results of the X-ray, MRI, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of the disability?  Yes  No  
If yes, please elaborate.

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should not** do)? Please be specific.

Please indicate the date the patient stopped working or performing his/her daily activities based on your recommendation. (YYYY/MM/DD)

If a potential return to work date or return to daily activities has been discussed, please provide the date and indicate if the return is (YYYY/MM/DD)  
 Part-time  Full-time  Temporary assignment  Light duties  Gradual – Please provide the return to work protocol

Has the patient ever had the same or similar condition?  Yes  No If yes, please provide dates and complete description.

Is the patient's condition due to injury or sickness arising out of his/her employment?  Yes  No If yes, please elaborate.

**Attending physician statement – physical conditions (continued)**

**Section B – Treatment - (suite)**

Is your patient  Right-handed  Left-handed

Is your patient competent to manage his/her own financial affairs?  Yes  No

If the patient was/is pregnant, please indicate the date or expected date of delivery.

(YYYY/MM/DD)

**Section C – Treatment**

Frequency of patient visits  Weekly  Bi-weekly  Monthly  Other \_\_\_\_\_

Please detail the patient's past and present treatment (e.g.: date and type of surgery) as well as response to treatment.

Has the patient been hospitalized?  Yes  No If yes, please provide the name of the hospital(s) and the dates of admission.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Have you treated or has the patient consulted you during the last **5 years prior** to the last illness?  Yes  No

Did the patient, to your knowledge, receive treatment during the **last 5 years** from any other health professional, or in any hospital or institution?  Yes  No

If «Yes», to either question, please furnish the following:

Name	Address	Nature of illness or injury	Dates
			(YYYY/MM/DD)
			(YYYY/MM/DD)
			(YYYY/MM/DD)

Signature	Date (YYYY/MM/DD)	
Name (please print)	Specialty	License no.
Address (no., street)		
Telephone no.	Fax no.	



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**Attending physician statement – psychological conditions**

**In order for Humania Assurance to properly assess your patient’s claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.**

**Section A – Information about the patient**

Surname	Given name(s)	
Date of birth (YYYY/MM/DD)	Height	Weight

**Section B – Diagnosis**

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I
II
III
IV
V

Is there a secondary diagnosis or additional complication which might affect the duration of the disability?  Yes  No  
 If yes, please elaborate.

When did symptoms first appear? (YYYY/MM/DD)

Please provide a complete list of your patient’s symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

What was the date of the patient’s first visit for his/her current condition? (YYYY/MM/DD)

What was the date of the patient’s first visit during the present disability period? (YYYY/MM/DD)

Please describe the patient’s initial reason for seeking treatment. Was there a precipitating event?

Is your patient’s condition caused directly or indirectly by his/her employment?  Yes  No If yes, please elaborate.

What are the patient’s current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient’s current restrictions (things that he/she **should not** do)? Please be specific.

Is your patient competent to manage his/her own financial affairs?  Yes  No

Please indicate the date the patient stopped working or performing his/her daily activities based on your recommendation. (YYYY/MM/DD)

If a potential return to work date or return to daily activities has been discussed, please provide the date and indicate if the return is (YYYY/MM/DD)  
 Part-time  Full-time  Temporary assignment  Light duties  Gradual – Please provide the return to work protocol

**Attending physician statement – psychological conditions (continued)**

**Section C – Treatment**

Frequency of patient visits  Weekly  Bi-weekly  Monthly  Other \_\_\_\_\_

Please detail the patient’s past and present treatment (including psychotherapy), response to treatment, and compliance.

Has the patient been hospitalized?  Yes  No If yes, please provide the name of the hospital(s) and the dates of admission.

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

Have you treated or has the patient consulted you during the **last 5 years prior** to the last illness?  Yes  No

Did the patient, to your knowledge, receive treatment during the **last 5 years** from any other health professional or in any hospital or institution?  Yes  No

If «Yes», to either question, please furnish the following:

Name	Address	Nature of illness or injury	Dates (YYYY/MM/DD)

**Section D – Functional capacities evaluation**

Please provide your opinion as to the extent of the patient’s impairment in performing the following on a sustained basis:

**None:** no impairment in this area. **Moderately severe:** impairment significantly affects ability to function.

**Mild:** suspected impairment of slight importance which does not affect functional ability. **Severe:** extreme impairment of ability to function.

**Moderate:** impairment affects but does not preclude ability to function.

	None	Mild	Moderate	Moderately severe	Severe
1. Ability to relate to friends and family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ability to attend to personal care (bathing, cooking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ability to carry out household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ability to relate to co-workers and supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Perform work where contact with others will be minimal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Understand, carry out, and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Perform tasks involving minimal intellectual effort or repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Perform varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ability to follow a regular work schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Make independent judgements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Supervise or manage others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature	Date (YYYY/MM/DD)	
Name (please print)	Specialty	License no.
Address (no., street)		
Telephone no.	Fax no.	

To avoid any delay in the assessment of your claim, please complete and sign all the authorizations below, even if you completed the one found on page 3 of this document.



## Authorization

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Humania Assurance will use the information provided for this claim and any prior claims under the same plan for the management of my claim and for production or statistical reports.

**This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.**

_____	_____
Name (please print)	Signature
_____	_____
Policy no.	Date (YYYY/MM/DD)
Humania Assurance Inc., 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8	4300-013 - Rév. 04/2013



## Authorization

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_____	_____
Name (please print)	Signature
_____	_____
Policy no.	Date (YYYY/MM/DD)
Humania Assurance Inc., 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8	4300-013 - Rév. 04/2013



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_____	_____
Name (please print)	Signature
_____	_____
Policy no.	Date (YYYY/MM/DD)
Humania Assurance Inc., 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8	4300-013 - Rév. 04/2013









**HUMANIA ASSURANCE INC.**

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Montreal region: 514 485-7236

Saint-Hyacinthe region: 450 773-7236

Other region: 1 800 818-7236

Web site : [www.humania.ca](http://www.humania.ca)