ACCIDENTAL FRACTURE
Claim for payment

This form must be completed by the policyholder or, if unable to do so personally, by another person on the policyholder's behalf. The Insurer reserves the right to require any additional information it deems necessary. The Insurer assumes no liability for any expenses incurred in providing the proof required for claims.

INSTRUCTIONS: The Accidental Fracture claim form must be submitted within 90 days following the accident. Follow the steps below, complete the **Physician's declaration**, complete and sign the **Insured's declaration and authorization**.

DOCUMENTS TO SUBMIT: – Birth certificate of the insured involved in the accident – Copy of the medical report confirming the diagnostic

Step 1 IDENTIFICATION OF POLICYHOLDER

Contract: _____ Last name: _____ First name: _____

Address: _____ _____
Street City Province Postal code Tel.

Step 2 IDENTIFICATION OF THE INSURED INVOLVED IN THE ACCIDENT

Full name: _____ Date of birth: ____ ____ ____ Gender: ☐ F ☐ M
Year Month Day

Relation to policyholder **(submit birth certificate)**

☐ Same person ☐ Dependent child of the policyholder
☐ Spouse

If the dependent child is a student between the ages of 18 and 24, please **submit proof of enrolment.** who attends a recognized educational institution on a full-time basis as a duly registered student.

Step 3 DESCRIPTION OF ACCIDENT

Place: _____ Date of accident: ____ ____ ____ Time: _____ : _____
Year Month Day

Did the accident occur at work? ☐ Yes ☐ No

If yes, have you filed a Worker's Compensation claim? ☐ Yes ☐ No

Did the accident involve a motor vehicle? ☐ Yes ☐ No

If yes, have you filed an SAAQ claim? ☐ Yes ☐ No

Describe the circumstances of the accident. _____

Step 4 ATTENDING PHYSICIAN'S DECLARATION

Date of the accident causing the fracture(s): ____ ____ ____
Year Month Day

Date of the first consultation for this condition: ____ ____ ____
Year Month Day

List the fractured bones (please include a copy of any investigative reports confirming the diagnostic(s):

If a skull fracture, has it caused permanent neurological damage? ☐ Yes ☐ No

If yes, has your patient become irreversibly limited or impaired in his or her ability to carry out activities of daily living? ☐ Yes ☐ No

If yes, please indicate: _____

To your knowledge, does the patient suffer from any illness that could have contributed in whole or in part to these fractures? ☐ Yes ☐ No

If yes, list the illness? _____

Since when? ____ ____ ____
Year Month Day

Name of physician: _____ Tel.: _____

Date: _____ Signature: _____

The insured individual is responsible for any fees charged for completing the "Attending physician's declaration."

Step 5 INSURED'S DECLARATION AND AUTHORIZATION

Contract: _____

I hereby declare that to the best of my knowledge the information entered on this form is correct. I authorize any health care professional, medical establishment, private or public agency, my employer, any natural person or legal entity and any insurance company holding personal information, including medical reports, about me or my insured child, to disclose it to the Insurer for purposes of evaluating my claim. A photocopy of this authorization shall be considered as valid as the original.

Date: _____ Signature of insured (if a minor, signature of the parent or legal guardian): _____

La Capitale Civil Service Insurer Inc. (the Insurer)
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