La Capitale

Claim form
HOSPITALIZATION DUE TO COVID-19

INFORMATION REGARDING THE INSURED

Last name

First name

Date of birth: Year Month Day Sex: ☐ F ☐ M

Contract No.

Client No.

Address (No., street, apt., city, province)

Postal code

INFORMATION REGARDING THE HOSPITALIZED PERSON (CLAIMANT)

Last name

First name

Date of birth: Year Month Day Sex: ☐ F ☐ M

Relationship to the insured

Address (No., street, apt., city, province)

Postal code

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 THE CLAIM.

INFORMATION REGARDING COVID-19

1 Date of the onset of the first symptoms: Year Month Day

2 Please describe these symptoms. _____

3 Date the person tested positive for COVID-19: Year Month Day

4 Name of the physician who confirmed the diagnosis of COVID-19: _____

5 What were the dates of the person's hospitalization for this condition? From Year Month Day to Year Month Day

6 Where was the person hospitalized (name of the hospital centre, city): _____

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ATTENDING PHYSICIAN'S STATEMENT

I confirm that the information on page 1 of this form with regard to the diagnosis of COVID-19 and hospitalization are true.

Signed at _____ on this _____ day of _____ 20_____.

_____ _____
Physician's signature | Physician's full name (please print)

_____ _____
Address (No., street, city, province) | Postal code

_____ _____ Licence No.: _____
Area code | Telephone

STATEMENT AND AUTHORIZATION OF THE HOSPITALIZED PERSON (CLAIMANT)

1. I certify that all the information on page 1 of this form is true and complete.
2. I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, the MIB, Inc., financial institutions, insurance and reinsurance companies, personal information agents, investigation agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of managing my file and considering my claims. For the same purposes, I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc.
3. A photocopy of this authorization is considered as valid as the original.

Signed at _____ on this _____ day of _____ 20_____.

SIGNATURE OF THE HOSPITALIZED PERSON (CLAIMANT)

_____
Signatures of the hospitalized person (claimant) (authorized to sign if age 14 or over in Quebec or age 16 or over outside Quebec)

_____ _____
Signature of the parent or legal guardian if the hospitalized person (claimant) is a minor | Name of parent or legal guardian signatory (please print)

FILING THE CLAIM

Email the duly completed form to claims@lacapitale.com or mail it to:

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive
Mississauga ON L5W 0E5

The Insurer reserves the right to make any verifications for the purposes of administering this claim as well as to request any supplementary information deemed necessary.