

**The veterinarian must do the following** as soon as a claim is filed against him or her, or as soon as he or she becomes aware of any facts, circumstances or allegations that could lead to a claim:

1. Dial **1 866 906-2120** to open a file and obtain a number. This number must be indicated below and used when sending documents.
2. Complete this form and attach all documents relevant to the claim.

## Section 1

### 1. Insured

Veterinarian's name: \_\_\_\_\_ Member/permit number: \_\_\_\_\_

File No.: \_\_\_\_\_ Date of first notice received by client: 

Y	Y	Y	Y	M	M	D	D
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(Obtained when the file was opened)

Date of loss (date of procedure): 

Y	Y	Y	Y	M	M	D	D
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Clinic (name of clinic): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: 

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Veterinarian (contact information): \_\_\_\_\_

Email: \_\_\_\_\_

Cell: 

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 Work tel.: 

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### 2. Claim details

**Name of claimant or client named in claim:** \_\_\_\_\_

Address: \_\_\_\_\_

Postal code: 

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 Email: \_\_\_\_\_

Phone: 

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Claimant's lawyer (if applicable): \_\_\_\_\_

Name of lawyer's law firm (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Postal code: 

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 Email: \_\_\_\_\_

Phone: 

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#### Animal:

Species: \_\_\_\_\_

Breed: \_\_\_\_\_ Age: \_\_\_\_\_

#### Place of loss:

- ☐ Clinic
- ☐ At the claimant's home
- ☐ Other location. Please specify: \_\_\_\_\_

3. Circumstances (please summarize)

4. Claim amount

**Note:** Please provide us with your estimate of the claim value if no amount has been claimed yet: \$ \_\_\_\_\_

Date on which professional services resulting in or likely to result in a claim were rendered: 

Y	Y	Y	Y	M	M	D	D
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Date on which you became aware of the claim or the possibility of a claim: 

Y	Y	Y	Y	M	M	D	D
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5. Nature of loss

Provide a chronological description of the facts and circumstances pertaining to the incident or claim (history, symptoms, examination, diagnosis, treatment, etc.). **Attach extra pages as needed.**

Section 2

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For cases where the animal deceased, was an autopsy performed? ☐ Yes ☐ No  
If yes, attach copy of autopsy report.

In your view, your liability is:

- ☐ Non-existent
- ☐ Likely
- ☐ Incurred

Please specify:

List of attached documents

Please list the documents you have attached to this form.

# Veterinary's signature

I certify that all information contained in this declaration and the supporting documents are true and genuine.

X

Signature

Y Y Y Y M M D D

Date

Per: 

Name (please print)

Authorization for communicating information

This declaration and the documents to be attached thereto will be sent by Beneva Inc. (hereafter referred to as Beneva) to the lawyer assigned to the file or the claims adjuster responsible for the investigation. Please note that under section 62.2 of the Professional Code (CQLR, c. C-26), you are obliged to inform the secretary of the Ordre des médecins vétérinaires du Québec (OMVQ) of any declaration of loss that you file with Beneva with regard to your professional liability. For the purpose of complying with this requirement and resolution 112-CA-0022 of the Board of Directors of the Ordre des médecins vétérinaires du Québec, Beneva may inform the OMVQ that you filed notice, if you authorize us to do so. Beneva does not assume any liability with regard to how the OMVQ may use the information that is submitted to it with your approval.

If you received an originating application (a lawsuit), you must send it upon receipt to Beneva and to the secretary of your professional order.

**By signing this form, I authorize Beneva to disclose the information indicated in section 1 as well as certain information related to the settlement of the claim by Beneva, namely the amount of the claim incurred and relevant details.**

X

Signature

Y Y Y Y M M D D

Date

Per: 

Name (please print)

Please return this form, a copy of the claimant's medical file and any other document related to this declaration by email to [courrier@beneva.ca](mailto:courrier@beneva.ca)

**Note:** Please include the file number in the email subject.