



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

IMPORTANT!

1. TO AVOID DELAY, ENSURE YOUR FORM IS **SIGNED** AND **FULLY** COMPLETED.
2. ANY CHARGE FOR COMPLETING THIS FORM IS THE INSURED'S RESPONSIBILITY.
3. ALL CLAIMS ARE HANDLED AT OUR HEAD OFFICE IN MISSISSAUGA. CALL US DIRECTLY WITH ANY INQUIRIES, TOLL-FREE, 1 800 268-2835 (OUTSIDE TORONTO CALLING AREA) OR 905 795-2300 IN THE TORONTO AREA.

CLAIMANT'S PRELIMINARY REPORT

POLICY N^o

YOUR HOME PHONE	AREA CODE
YOUR CELL PHONE	AREA CODE
YOUR WORK PHONE	AREA CODE

INSURED'S NAME _____ DATE OF BIRTH _____
 IF CLAIM IS FOR DEPENDENT, GIVE NAME _____ AGE _____ RELATIONSHIP _____
 WHAT OTHER DISABILITY OR MEDICAL INSURANCE DO YOU HAVE? _____
 PLEASE PROVIDE NAME OF COMPANY AND POLICY NUMBER _____

O C C U P A T I O N	Employer's name and address _____ Your Occupation _____ Net earned annual income \$ _____ Describe your usual duties _____ Were you working before you became disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what were you doing? _____
T R E A T M E N T	When did you first receive medical treatment? _____ Where? _____ What is your Doctor's name? _____ How long has he/she been your Doctor? Since _____ Doctor's address _____ List other Doctors who have treated you? (Name/Address) _____ If you were in the hospital, please give dates of confinement: Admitted _____ Discharged _____ Hospital _____ Address _____
C O N D I T I O N	Describe the sickness or injury _____ What are your physical complaints? _____ If this is a sickness, when did it first begin? _____ If this is an accident, when and where did it happen? Date and Time _____ Place _____ *(If Motor Vehicle Accident, please include the Police Report) How did it happen? _____ Have you had this condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____ Doctor _____
D I S A B I L I T Y	Did the condition described above cause you to lose any time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, between what dates were you unable to do any work? First day not worked _____ Date returned to work – Part time _____ Full time _____ What duties are/were you unable to do? _____ If you are self-employed, is business still operating? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what duties are you involved in? _____ If unemployed, retired or housewife, what period of disability are you claiming: Total Disability _____ Partial Disability _____

AUTHORIZATION

I CERTIFY that the above information is current, correct and complete.
 I HEREBY AUTHORIZE La Capitale Financial Security Insurance Company, its authorized agents and reinsurers, for file management and claim settlement purposes only: a) to gather all information necessary for claim settlement and the management of my file from any person, organization or public or parapublic institution holding personal information about me, notably from health professionals and health centres, the MIB, Inc., financial institutions, Government agencies, Provincial Workers Compensation Organization, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, employers or previous employers; b) to disclose to such individuals and organizations only that personal information it has relating to me that is relevant to my file or that is required by law; c) to request an investigation report relating to me.
 A photocopy of this authorization shall be as valid as the original. This authorization is valid for the period required to achieve the purpose for which it was requested.
 I acknowledge that the Company may refuse to consider my claim if I do not comply completely with this authorization.

Insured Sign Here _____ Witness Sign Here _____
 Address _____ Address _____
 City & Province _____ Date _____ City & Province _____ Date _____

ATTENDING PHYSICIAN'S REPORT

PATIENT'S NAME: _____ Age: _____ My patient since: _____

1. Diagnosis and concurrent conditions.

2. When did symptoms first appear or accident happen? Cause: Accident Disease
 Gradual or Progressive Onset

3. Please describe history presented. If accident, please describe.

4. When did patient first consult you for this condition? Date _____ Time _____ AM
 PM

5. A. Has patient ever had same or similar conditions? Yes No
If "Yes" state when and describe.
B. If treated by another physician, please give name and address.

6. Describe any other disease or infirmity affecting present condition.

7. Nature of surgical procedure: _____ Date performed: _____

8. If patient confined, give name and address of facility Name _____
City and Province _____
 Hospital Long Term Care Facility Admitted _____ Discharged _____
 Rehab Centre Adult Day Care Intensive Care from _____ To _____

9. Please describe nature of treatment _____
Give dates of treatment Office _____
 Hospital _____
 Physiotherapy _____

10. Is this patient still under your care for this condition? Yes
If "No" give date your service terminated. No

11. If **housewife, retired or unemployed**, No activity From _____ To _____
please indicate a reasonable period of recovery Partial activity From _____ To _____

12. How long was (or will) patient (be) continuously totally disabled? (Unable to work) From _____ To _____

13. How long was (or will) patient (be) partially disabled? (Able to perform some but not all of his/her occupational duties)? From _____ To _____

14. If patient is still disabled, please indicate present physical restrictions or limitations.

15. Names of other insurers, compensation or Government agencies reported to.

REMARKS

DATE _____ SIGNED _____ MD

ADDRESS _____ CITY _____

PROVINCE _____ POSTAL CODE _____ TELEPHONE (_____) _____ FAX (_____) _____
AREA CODE AREA CODE

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR ANY CHARGES MADE FOR ITS COMPLETION.