La Capitale
Financial Security
7150 Derrycrest Drive, Mississauga, ON L5W OE5 lacapitaleFS.com

CLAIMANT'S PRELIMINARY REPORT

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.

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 _____

OCCUPATION

Employer's name and address _____

Your Occupation _____ **Net** earned annual income $_____

Describe your usual duties _____

_____

Were you working before you became disabled? ☐Yes ☐No If No, what were you doing? _____

_____

TREATMENT

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 _____

CONDITION

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? ☐Yes ☐No If Yes, when? _____ Doctor _____

DISABILITY

Did the condition described above cause you to lose any time from work? ☐Yes ☐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? ☐Yes ☐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, 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** _____

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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.