Accident – Proof of Loss:

Disability / Dismemberment

The furnishing of this form and the investigation of the claim shall not be construed as an admission of any liability on the part of the insurer, nor a waiver of any of the conditions of the insurance contracted.

Parts 1, 2 and 3 should be completed by the Claimant, Parts 4 and 5 by the Attending Physician.

Part 1 – Claimant

Name of credit union	
Name of claimant	Date of birth *(mm/dd/yyyy)*
Address *(include street address, city, province and postal code)*	
Name and address of employer	
Occupation and duties	

Part 2 – History of Injury or Disability Statement

1. Date of Accident: ______ at ____ ☐ am ☐ pm

2. Describe in detail how and where the accident occurred:

3. Were you at work? ☐ YES ☐ NO Describe injuries:

4. When did you become totally or partially disabled so as to be prevented from doing any work? *(mm/dd/yyyy)*

5. Were you confined to a hospital? ☐ YES ☐ NO

Name of hospital			
Address *(include street address, city, province and postal code)*			
Admitted date *(mm/dd/yyyy)*	Admitted time ☐ am ☐ pm	Discharged date *(mm/dd/yyyy)*	Discharged time ☐ am ☐ pm

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Part 2 – History of Injury or Disability Statement *(continued)*

6. What physicians have you consulted during your present disability and for all causes during the last five years?

Name of physican 1	
Address 1 *(include street address, city, province and postal code)*	
Dates *(mm/dd/yyyy)*	Disease or condition
Name of physican 2	
Address 2 *(include street address, city, province and postal code)*	
Dates *(mm/dd/yyyy)*	Disease or condition

7. If not totally disabled, when were you able to perform part of the duties of your occupation? *(mm/dd/yyyy)*

Indicate what important duties you were able to perform during such partial recovery:

8. When were you able to return to full time work? *(mm/dd/yyyy)*

9. If still disabled, when do you expect to be able to return to full time work? *(mm/dd/yyyy)*

Part 3 – Claimant Signature

I hereby authorize any Hospital, Physician, or other person who has attended or examined me, to disclose when requested to do so by the Insurer or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Claimant signature	Date *(mm/dd/yyyy)*
Address *(include street address, city, province and postal code)*	

PLEASE HAVE PHYSICIAN COMPLETE AND SIGN PARTS 4 AND 5

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Part 4 – Attending Physician's Statement

Patient name	Date of injury *(mm/dd/yyyy)*

1. Nature of injury *(Describe complications if any)*

2. If fracture or dislocation, state whether complete or incomplete:

3. When did symptoms first appear or accident happen? *(mm/dd/yyyy)*

4. When did patient first consult you for this condition? *(mm/dd/yyyy)*

5. Has patient ever had same or similar condition? ☐ YES ☐ NO

If "YES", state when and describe

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

7. Describe the nature of surgical procedures and provide the dates and types of treatment:

8. Is patient still under your care for this condition? ☐ YES ☐ NO

If "NO", give date: *(mm/dd/yyyy)*

9. If patient hospitalized, give name and address of hospital

Name of hospital
Hospital Address *(include street address, city, province and postal code)*

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Part 4 – Attending Physician's Statement *(continued)*

10. Is the patient still totally disabled (unable to perform most of the duties of his/her regular occupation): ☐ YES ☐ NO

If "YES", please provide date the patient will be able to resume his/her regular occupation: *(mm/dd/yyyy)*

If "NO", provide date when patient was or will be capable of resuming his/her regular occupation: *(mm/dd/yyyy)*

Comments:

Part 5 – Physician Signature

Attending physician signature	Date *(mm/dd/yyyy)*
Address *(include street address, city, province and postal code)*	

CUMIS General Insurance Company, P.O. Box 5065, 151 North Service Rd., Burlington, ON L7R 4C2
Telephone: 905.632.1221 Toll-Free: 1.800.263.9120 Fax: 905.632.3005 / 1.866.658.3844

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