



# CLAIMANT'S STATEMENT ACCIDENTAL FRACTURE

**ATTENTION:**  
**ATTACH A COPY OF THE RADIOLOGIST'S REPORT.**  
**THE CLAIMANT IS RESPONSIBLE FOR ANY FEES FOR THE RADIOLOGIST'S REPORT.**

	Agent	Agency	Code	S.U.
<b>1. CONTRACT NUMBERS</b>	<b>2. Insured's last name</b>			
	<b>3. First name(s)</b>			Date of birth Y      M      D
	<b>4. No.</b>	<b>5. Street</b>		<b>6. Apt.</b>
	<b>7. City</b>		<b>8. Province</b>	<b>9. Postal code</b>
	<b>10. Tel. no. (home)</b>		<b>11. Social Insurance Number</b>	
<b>12. Fracture (specify which bone(s))</b>				
<b>13. Date of the accident</b>				
<b>14. Place where the accident occurred</b>				
<b>15. How did the accident happen?</b>				
<b>16. People present (witnesses)</b>				
<b>17. Were the police called to the scene of the accident?</b>				
<b>18. Hospital where the fracture was treated</b>				
<b>19. Physician's name</b>				
<b>20. Date on which the fracture was diagnosed</b>				

I declare that the information provided in this claim is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

I consent to release the information contained in this claim form to **Industrial Alliance Insurance and Financial Services Inc.** or its affiliate **Industrial Alliance Pacific Insurance and Financial Services Inc.** (the companies) and acknowledge that this information will be used to assess, process, and administer this claim and policy coverage. I authorize any other insurers, reinsurers, and financial institutions, physicians, medical institutions and healthcare providers, employers or administrators of group benefits, agents or brokers, investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to this claim, to provide it to the companies.

I authorize the companies to exchange the information detailed in the claim form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Claimant's signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address of claimant

\_\_\_\_\_  
Address of witness

Home tel.: \_\_\_\_\_

Office tel.: \_\_\_\_\_