Assumption Life
Group Insurance

Reset

Accidental Dismemberment Claim Form Employee's Statement

First Name _____ Last Name _____ Policy _____ Division _____ Certificate _____

Address _____ City _____ Province _____ Postal Code _____

Date of Birth (DD/MM/YYYY) ___/___/_____ Telephone - Home _____ Telephone - Cell _____

A) Date of Accident: (DD/MM/YYYY) ____/____/_____ Time of Accident: _____

B) Where did the accident happen? ☐ Home ☐ Work ☐ Elsewhere (specify) _____

C) How did the accident happen? Please give complete description. _____

Please attach a copy of the accident report.

D) I am claiming Accidental Dismemberment Benefits due to the loss of: _____

I authorize any physician, practitioner or other health care provider, hospital, clinic or other medical facility, pharmacy, insurer, employer (past and present), workers' compensation plan, medical or benefit payment plan, service provider, and any other institution, person or party that has any record or knowledge of myself, to give to Assumption Life full particulars of such information, including, without limiting the generality of the foregoing, any information regarding my lifestyle, health, prior medical history and benefits.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional or medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

I hereby certify that the information given above is true and complete and authorize the release of any information requested with respect to this claim to the insurer and its authorized representatives.

A photocopy or electronic version of this acknowledgement shall be as valid as the original.

Employee's Signature _____ Date (DD/MM/YYYY) _____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 E-mail: lifedisability@assumption.ca