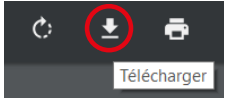
Steps to complete the form

1 Click on the download button for save the form on your computer.



2 Fill in the fields of the form and save your information before submitting it to us.

UV INSURANCE

GROUP INSURANCE

NEW CLAIM - NON COVID-19 RELATED

Please complete **only** in the absence of an Attending Physician's Statement.
In that case, we require confirmation of your symptoms, any test results, and any medical treatment you may have received for your condition.

Section A – Identification

1. First Name: _____ Last Name: _____
2. Group Number: _____ Certificate Number: _____
   Plan Member Name: _____ Plan Sponsor Name: _____
3. Email: _____
4. Phone Number: [ ][ ][ ] [ ][ ][ ]-[ ][ ][ ][ ] Cell Phone Number: [ ][ ][ ] [ ][ ][ ]-[ ][ ][ ][ ]

Section B – Declaration

1. **For illness**
   Date symptoms first appeared: [Y][Y][Y][Y][M][M][D][D]
   For injury
   Date of accident/injury: [Y][Y][Y][Y][M][M][D][D]
2. First day absent from work: [Y][Y][Y][Y][M][M][D][D]
3. What has prompted you to stop working?

   _____
4. Did you consult with a treatment provider for your injury/symptoms and work absence? ☐ No ☐ Yes

   If yes, please provide information about this treatment provider
   Name: _____ Specialty: _____
   Location: _____ Phone Number: [ ][ ][ ] [ ][ ][ ]-[ ][ ][ ][ ]
   When did you consult this treatment provider? [Y][Y][Y][Y][M][M][D][D]

   If no, please provide details as to why you did not seek medical attention for your condition:

   _____
5. Please provide any current test result as well as detail if you have upcoming tests or other appointments (i.e. specialist) scheduled regarding this condition. Please elaborate:

   _____
6. Please list the symptoms associated with your illness/injury and the severity of each symptoms:

Symptom	Severity		
	Mild	Moderate	Severe
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

7. How are these symptoms affecting your ability to work?

   _____
8. Please provide details about what you discussed with your employer, regarding how you could be accommodated to address the barriers you have identified in the previous question?

   _____

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9. Do you have an anticipated return to work date? ☐ No ☐ Yes If so, when? [Y Y Y Y M M D D]

10. Do you have any other health problems that might affect your recovery (e.g. diabetes, heart disease, respiratory illness)? Please elaborate:

11. **Diagnosis**
Primary: _____
Secondary and/or complications: _____

If Childbirth
Expected or Actual Delivery Date: [Y Y Y Y M M D D] ☐ Vaginal ☐ C-Section

12. Is your condition due to a work related illness/injury? ☐ No ☐ Yes If yes, date of the event: [Y Y Y Y M M D D]

13. Is your condition related to a car accident? ☐ No ☐ Yes If yes, date of the event: [Y Y Y Y M M D D]

14. Have you been hospitalized for this condition? ☐ No ☐ Yes If yes, date of the event: [Y Y Y Y M M D D]
If you have been hospitalized for this condition, please provide any documents you received upon discharge.

15. Date of discharge: [Y Y Y Y M M D D] Name of the Institution: _____

16. Have you had surgery for this condition? ☐ No ☐ Yes
If yes, please provide date and description of surgery : [Y Y Y Y M M D D]
Healthcare establishment : _____
Description: _____

17. Treatment description (i.e. medication, dosage)

18. Have you had therapy for your condition? ☐ No ☐ Yes
If yes, please provide information about your therapist:
Name: _____ Specialty: _____
Address: _____ Phone Number: [ ] [ ]-[ ]
What date did you see your therapist?: [Y Y Y Y M M D D]
Have you continued to receive therapy from this provider since March 2020? ☐ No ☐ Yes Please elaborate:

19. Have you been treated for this same or similar condition in the past? ☐ No ☐ Yes If yes, date: [Y Y Y Y M M D D]

20. Any other details relating to your illness you would like us to know?

Section C – Attestation and Authorization

We would reserve the right to pursue recovery of benefits improperly paid for any reason, fraud or otherwise. The submission of fraudulent claims is a criminal offence and is taken seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

I certify that the foregoing information is accurate and complete and authorize any doctor, hospital, clinic. Insurance company or other organism, including workers' compensation board, S.A.A.Q. and employment insurance and immigration Canada or any other institution or person in custody of a file or personal information or on my health condition to transmit to UV Insurance any information on my health condition and my medical history. A photocopy of this authorization shall be as valid as the original.

[Y Y Y Y M M D D] **X** _____
Employee's signature

A photocopy of this authorization shall be as valid as the original.

Please return the original copy at the following address: P.O. Box 696, Drummondville (Québec) J2B 6W9 or through the online portal at: https://apps.uvmutuelle.ca/CollectifAdherents/. Keep a copy for your records.

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