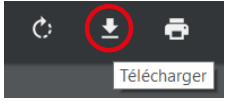
Steps to complete the form

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

UPDATE TO AN ONGOING CLAIM

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. 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

Please indicate the reason for submitting this update:

☐ Extension of benefits for a current claim ☐ New/additional condition

☐ Change in my existing condition (i.e. medication/dosage, testing, treatment)

1. Diagnosis

   Primary: _____

   Secondary and/or complications: _____

   If Childbirth

   Expected or Actual Delivery Date: [Y][Y][Y][Y][M][M][D][D] ☐ Vaginal ☐ C-Section
2. Please list the symptoms associated with your illness/injury and the severity of each symptoms:

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

3. How are these symptoms impacting your ability to work?

4. Have you discussed with your employer how you could be accommodated to address the barriers you have identified in the previous question?

5. Do you have an anticipated return to work date? ☐ No ☐ Yes If so, when?: [Y][Y][Y][Y][M][M][D][D]
6. Do you have any other health problems that might affect your recovery (e.g. diabetes, heart disease, respiratory illness)?

7. Is your condition due to a Occupational Illness/injury? ☐ No ☐ Yes If yes, date of the event: [Y][Y][Y][Y][M][M][D][D]
8. Is your condition related to a car accident? ☐ No ☐ Yes If yes, date of the event: [Y][Y][Y][Y][M][M][D][D]
9. Have you been hospitalized for this condition since the last update. ☐ No ☐ Yes Date of admittance: [Y][Y][Y][Y][M][M][D][D]

   If you have been hospitalized for this condition, you must obtain the discharge notes and submit these with your update.
10. Date of discharge: [Y][Y][Y][Y][M][M][D][D] Name of institution: _____

EN-5006A (2020-04)

11. Have you had surgery for this condition since the last update? ☐ No ☐ Yes
If yes, please provide date and description of surgery: Y Y Y Y M M D D
Description: _____

12. Current treatment description (i.e. medication, dosage)

13. Have you received therapy for our condition? ☐ No ☐ Yes
If yes, please provide information about our therapist:
Name: _____ Specialty: _____
Location: _____ Phone Number: ___ ___ - ___ ___
What date did you last see your therapist? Y Y Y Y M M D D
Are you continuing to receive therapy from this treatment provider? ☐ No ☐ Yes Frequency: _____
Please elaborate:

14. Are you following the plan outlined by your treatment provider (i.e. medication, therapy) ☐ No ☐ Yes
If no, please explain:

15. Have you been referred for any testing? ☐ No ☐ Yes Type of testing : _____ Date: Y Y Y Y M M D D
Results (if known) **Please attach a copy of the testing report if available**

16. Have you been referred to a specialist? ☐ No ☐ Yes Date of the visit: Y Y Y Y M M D D
Name of specialist: _____ Specialty: _____
Results of consultation (if known) **Please attach a copy of the consultation report if available.**

17. 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 (Quebec) J2B 6W9 or through the online portal at: https://apps.uvmutuelle.ca/CollectifAdherents/. Keep a copy for your records.