OneMain Solutions

TYPE 0405

Underwritten by:
Triton Insurance Company
1420-380 Wellington St
London, Ontario N6A 5B5
T 800-285-8623 | Fax 877-772-2623

Disability Claim Form

Insured Name:

Branch/Account Number:

Branch Mailing Address:

Date received in branch: M M / D D / Y Y

FORM COMPLETION INSTRUCTIONS

1. Fully complete all sections and spaces on the form.
2. If a question is not applicable, a line should be drawn through the space provided for the answer.
3. Attach a copy of the Loan Protection Insurance Application, the Credit Application and Ledger Cards # 1 & 2 or the Symphony equivalent.

NOTE: Altered forms cannot be accepted.

SUBMISSION INSTRUCTIONS

1. When all required sections are complete, return the form to the office listed above.
2. Keep a copy of the entire form and any attachments for your records.
3. If the form is not fully completed with all attachments, the processing will be delayed.
4. If you choose to email the claim to InsClaims@onemainfinancial.com, please be aware email is not considered a secure method of delivery for personal/medical information.
5. Please allow 15 days after submitting for processing fully completed forms.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the applicable provincial legislation: In Alberta - *Insurance Act*; In British Columbia, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, Northwest Territories and Nunavut - *Insurance Act*; In Manitoba - *The Insurance Act*; In Ontario - *Limitations Act of 2002*; In Saskatchewan and Newfoundland - *The Limitations Act*; In Quebec - *The Civil Code of Quebec*.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Triton Insurance Company collects, uses and discloses personal information about you as described: (1) in the Triton Insurance Company Privacy of Personal Information Statement (a copy of which can be obtained at the address above); (2) in *the Personal Information Authorization* section of this form; and (3) referenced in the creditor insurance application form that relates to your claim. We maintain a file containing your personal information for the purposes outlined in each of the above, accessible at 1420-380 Wellington Street London, Ontario N6A 5B5. Your file will only be accessible to employees, agents and other authorized representatives of Triton Insurance Company who are responsible for administering your file, and other persons authorized by you or by law.

We will not request genetic test results and if received inadvertently, we will not use genetic test results to determine eligibility for coverage or to determine claim benefits.

By signing and submitting this claim form on your own behalf , you give your consent to the collection, use and disclosure of personal information as described above and elsewhere in this claim form, including the Personal Information Authorization section of this claim form.

SIGNATURE: DATE: M M / D D / Y Y

PERSONAL INFORMATION AUTHORIZATION

I have read and fully understand the contents of the Notice Regarding Collection, Use and Disclosure of Personal Information ("Notice") and acknowledge and consent to Triton Insurance Company collection, use and disclosure of my personal information for the purposes identified in the Notice. For the purposes of claim investigation and processing, I hereby authorize, consent, and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, employer, any workers compensation board, Human Resources and Skills Development or any other organization, institution, association or person identified in the Notice that now has or may in future have any records or knowledge concerning me or my health, employment history, benefits paid or any related information to disclose to Triton Insurance Company, their authorized representatives and reinsurers, upon the request of Triton Insurance Company any such information that is material to the purposes identified in the Notice. A photocopy of this authorization shall be as valid as the original.

SIGNATURE: DATE: M M / D D / Y Y

1. STATEMENT OF INSURED Print or Type All Information. To be completed, signed and dated by the Insured.

Date last worked: M M / D D / Y Y

Date of birth: M M / D D / Y Y

Date unable to work due to disability: M M / D D / Y Y

Date you returned to work: M M / D D / Y Y

Is this a Worker's Compensation Board case? ☐Yes ☐No

If yes, please indicate the W.C.B. Case # and address.

Is this disability due to an: ☐Illness ☐Injury ☐Accident

Where and how did this disability occur? If accident, also provide date it occurred.

Have you had the same or similar illness or injury before? ☐Yes ☐No

If yes, when?

Please list below , or if additional space is needed on a separate page, the information for all doctors who have provided treatment in the past 2 years:

Name of doctor:

Date first contacted: M M / D D / Y Y

Doctor's complete mailing address:

Prov.:

Postal Code

Name of doctor:

Date first contacted: M M / D D / Y Y

Doctor's complete mailing address:

Prov.:

Postal Code

I certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my information, knowledge and belief.

SIGNATURE:

DATE: M M / D D / Y Y

COMPLETE MAILING ADDRESS:

CITY:

PROV.:

POSTAL CODE:

2. STATEMENT OF EMPLOYER To be completed by employer. If self-employed, please state.

Date last worked: M M / D D / Y Y

Date you returned to work: M M / D D / Y Y

If terminated, date: M M / D D / Y Y

COMPANY NAME:

TELEPHONE #: - -

COMPLETE MAILING ADDRESS:

CITY:

PROV.:

POSTAL CODE:

SIGNATURE OF INDIVIDUAL COMPLETING:

DATE: M M / D D / Y Y

PRINTED NAME:

TITLE:

3. STATEMENT OF ATTENDING PHYSICIAN

To be completed by the Attending Physician. Any fee for the completion of this form is the responsibility of the patient.

Our policy defines **total disability** as "a disability caused by an accidental injury or by sickness which continues uninterrupted for 30 or more consecutive days and causes the person insured to be unable to perform any duties of their principal job."

Primary diagnosis:

Contributing cause/complications of disability:

Surgical procedures and dates:

If pregnancy related, provide the estimated date of delivery and list any complications:

If hospitalized, provide dates:

From: M M / D D / Y Y Through: M M / D D / Y Y

Patient unable to work due to this disability:

From: M M / D D / Y Y Through: M M / D D / Y Y

Initial date of treatment: M M / D D / Y Y

All subsequent treatment dates:

Frequency of visits: ☐Weekly ☐Monthly ☐Other

The Disability is due to: ☐Injury ☐Illness ☐Accident

When did symptoms first appear or accident occur? M M / D D / Y Y

Has the patient ever had the same or a similar illness or injury before? ☐Yes ☐No

If yes, when? M M / D D / Y Y

Approximate date the patient will be able to return to work: M M / D D / Y Y

Was there a referring physician? ☐Yes ☐No

Referring physician's name:

Date of referral: M M / D D / Y Y

Referring physician's complete mailing address: City: Prov.: Postal Code:

SIGNATURE OF ATTENDING PHYSICIAN: DATE: M M / D D / Y Y

COMPLETE MAILING ADDRESS: CITY: PROV.: POSTAL CODE: