OneMain Solutions

Underwritten by:
Triton Insurance Company
1420-380 Wellington Street, London, Ontario N6A 5B5
T 800-285-8623 | Fax 877-772-2623
InsClaims@omf.com

Name _____ Account # _____ Claim # _____

Continuing Disability Claim Form

PERSONAL INFORMATION AUTHORIZATION

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 that now has or may have in future 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 administration of my claim. A photocopy of this authorization shall be as valid as the original.

By signing and submitting this claim form on your own behalf , you give your consent to the collection, use and disclosure of personal information

Signature _____ **Date** M M / D D / Y Y

NOTE: 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.

INSTRUCTIONS

1. **When all required sections are complete, return the form to the office listed above.**
2. **Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal/medical information.**

Note: Altered forms cannot be accepted.

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Continuing Disability Claim Form - Statement of Insured - To be completed by Insured

Have you returned to work? ❑ **Yes** ❑ **No** **If yes, date returned** M M / D D / Y Y

Complete mailing address **City** **Province** **Postal Code**

_____

I affirm the information I have provided herein is accurate and complete.

Signature _____ **Date** M M / D D / Y Y

Statement of Attending Physician - To be completed by the Attending Physician

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."

Patient unable to work due to disability **From** M M / D D / Y Y **Through** M M / D D / Y Y

Diagnosis

_____

Last visit date _____

Approximate date patient will be able to return to work _____ ❑ **1-3 months** ❑ **4-6 months** ❑ **7 months or longer** ❑ **Never returning**

Signature of attending physician **Date** MM /DD / YY

_____

Printed name

_____

Complete mailing address **City** **Province** **Postal Code**

_____

Telephone # **Fax #**

_____