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 # _____

# 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. **From Branch: Attach a copy of the Loan Protection Insurance Application, the Credit Application and most recent transaction history.**
3. **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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# Disability Claim Form - Statement of Insured - To be completed by Insured

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

**Date of birth** M M / D D / Y Y

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

_____

**Have you returned to work?** ☐ **Yes** ☐ **No** **If yes, date returned** _____

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

**If injury or accident, where and how did this disability occur? Provide date it occurred.**

_____

**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

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

_____

**Name of doctor** _____ **Date first contacted** 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

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Name _____ Account # _____ Claim # _____

# Disability Claim Form - Statement of Employer - To be Completed by Employer

**If self-employed, please state**

**Date last worked** M M / D D / Y Y

**Date employee returned to work** M M / D D / Y Y

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

**Signature of individual completing**

**Date** MM / DD / YY

**Printed name**

**Title**

**Company name**

**Complete mailing address**

**City**

**Province**

**Postal Code**

**Telephone #**

**Fax #**

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Name _____ Account # _____ Claim # _____

# Disability Claim Form - Statement of Attending Physician - To be Completed by Attending Physician

**Completed without expense to the insurance company.**

**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

**Initial date of visit** M M / D D / Y Y

**All subsequent visit dates** _____

**Primary diagnosis**

_____

**Contributing cause/complications of disability**

_____

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

_____

**Surgical dates**

_____

**If hospitalized, dates of hospitalization**

_____

**Is this disability due to an:**

☐ **Illness** ☐ **Injury** ☐ **Accident**

**Has patient ever had the same or similar condition** ☐ **Yes** ☐ **No** **If yes, when** _____

**Date symptoms first appeared or accident occurred**

_____

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

**Name of referring physician, if any** **Date of referral** MM /DD / YY

**Referring physician's complete mailing address** **City** **Province** **Postal Code**

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

**Printed name**

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

**Telephone #** **Fax #**