**CLAIMANT STATEMENT**

**Please print – Attach separate sheet if additional space required. Please complete all in MONTH/DAY/YEAR format.**

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| **CLAIM INSTRUCTIONS** |
| VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND MAKECHANGES WHERE REQUIRED.• COMPLETE THIS FORM IN FULL AND ATTACH ALL DOCUMENTS ASREQUESTED.• SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:Email**:** **ZurichGroup@crawco.ca**Mail: **Zurich Group Claims c/o Crawford & Company (Canada) Inc.,** **100 Milverton Drive, Suite 300****Mississauga, Ontario** **L5R 4H1****Fax: (905) 602-0185 / 877-364-6666** **FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.** | **PLEASE ATTACH THE FOLLOWING DOCUMENTS:*** CERTIFIED COPY OF DEATH CERTIFICATE (REQUIRED FOR ALL CLAIMS).
* CERTIFIED COPY OF ALL DOCUMENTS SUPPORTING CLAIMANT’S AUTHORITY (E.G., LETTERS TESTAMENTARY, OR LETTER OF ADMINISTRATION)
* PROOF OF RELATIONSHIP IF NAME DIFFERS FROM YOURS (E.G., MARRIAGE CERTIFICATE/COMMON-LAW STATUS/FOR CHILDREN BIRTH CERTIFICATE)

**PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.** |

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| **INSURED / POLICYHOLDER INFORMATION** |  |
| **Insured/Policyholder Name:** | **S.I.N. (last 4 digits only):** |
| **Date of Birth:** | **Marital Status:** |
| **Address:** |
| **City:** | **Province:** | **Postal Code:** |
|  **Home Phone:** |  **Mobile/Cell Phone:**  |  **Email:**  |
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| **Policy Number (Required):** |
| **Did the Insured have any other Accident or Life insurance?** [ ]  **Yes** [ ]  **No** **If “Yes”, please list all companies, type of insurance, Policy numbers and insurance amounts:** |
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|  **Name of Employer:**  | **Address of Employer:**  |
|  **Name of Deceased or Injured Person** |  **Date of Birth (MM/DD/YYYY)** |

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| **CLAIM INFORMATION** |  |
|  | **Time and Place Accident Occurred:** |
| **Country Where Accident Occurred:**  |
| **Please describe in detail the circumstances of the accident (attach a separate sheet if needed):** |
|  **Was an Autopsy Performed?** [ ]  **Yes** [ ]  **No**  |
|  **If “Yes”, please provide the Coroner’s contact information below.**  **Coroner’s Name: Address: Telephone Number:**  |
|  **Please list the names and addresses of all treating physicians and hospitals:** |
|  Physician Name: |  Address:  |
|  Physician Name: |  Address:  |
|  Physician Name: |  Address: |
| **Did the police or other authorities investigate the accident?** [ ]  **Yes** [ ]  **No** [ ] **If “Yes”, please provide the name(s), address(es) and phone number(s) of all investigating officers and agencies:**  |
| **Was an autopsy performed?** [ ]  **Yes** [ ]  **No** **If “Yes”, please provide the name and address of the Medical Examiner:** |
|  Physician Name: |  Address:  |
| **Was a coroner’s inquest held?** [ ]  **Yes** [ ]  **No** **If “Yes”, what was the determination?** |

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| **CLAIMANT INFORMATION (if different than the “Insured Information” above)** |
| **Claimant’s Name:** | **Age:** | **Relationship to Insured:** |
| **Claimant’s Address:** |
| **City:** | **Province:** | **Postal Code:** |
| **Phone # (H): ( )** | **Phone # (W): ( )** |
| **In what capacity are you making this claim?****Card Holder** [ ]  **Executor\*** [ ]  **Administrator\*** [ ]  **Assignee\*** [ ] **\*Please provide all documents supporting your authority (e.g., Letters Testamentary, Letters of Administration, etc.)** |

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|  **CERTIFICATE AND AUTHORIZATION**  |
| **ZURICH CANADA**, ITS AGENTS AND AUTHORIZED ADMINISTRATORS (HEREINAFTER “THE INSURER”, OR “THEY”) ARE OBLIGED TO COLLECT AND RETAIN CERTAIN PERSONAL AND/OR HEALTH INFORMATION ABOUT YOU IN CONNECTION WITH YOUR INSURANCE COVERAGE. THEY USE AND DISCLOSE THAT INFORMATION ONLY FOR THE PURPOSES OF ADMINISTERING YOUR POLICY OF INSURANCE, PROVIDING CUSTOMER SERVICE AND ASSESSING AND PAYING CLAIMS. IN CONSIDERATION OF PAYMENT MADE ON MY BEHALF, I AUTHORIZE ANY BENEFITS PAID OR PAYABLE BY ANY OTHER INSURANCE CARRIER, IN RESPECT TO THIS CLAIM TO BE ASSIGNED IN WHOLE OR IN PART TO CRAWFORD & COMPANY (CANADA) INC., FOR THE BENEFIT OF THE INSURANCE COMPANY UNDERWRITING THE POLICY FOR WHICH SUCH PAYMENT IS MADE. **PERSONAL INFORMATION NOTICE**I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIM, IS REQUIRED BY THE INSURER, ITS REINSURERS TO ASSESS MY ENTITLEMENT TO BENEFITS, INCLUDING BUT NOT LIMITED TO DETERMINING IF COVERAGE IS IN EFFECT, INVESTIGATING THE APPLICABILITY OF EXCLUSIONS. FOR THESE PURPOSES, THE INSURER WILL ALSO CONSULT ITS EXISTING INSURANCE FILES ABOUT ME, COLLECT ADDITIONAL INFORMATION ABOUT AND FROM ME, AND WHERE REQUIRED, COLLECT INFORMATION FROM AND EXCHANGE INFORMATION WITH THIRD PARTIES.**PRIVACY STATEMENT**YOUR PERSONAL INFORMATION MAY BE PROCESSED AND STORED BY ZURICH CANADA AND ITS AFFILIATES (COLLECTIVELY, “**ZURICH CANADA**” AND AUTHORIZED REPRESENTATIVES, BOTH IN DOMESTIC AND FOREIGN JURISDICTIONS OUTSIDE CANADA AND IS SUBJECT TO APPLICABLE LAWS. PLEASE CONTACT THE **ZURICH CANADA** PRIVACY OFFICER IF YOU REQUIRE FURTHER ADDITIONAL INFORMATION REGARDING THE COLLECTION, USE, DISCLOSURE, PROCESSING AND STORAGE OF YOUR PERSONAL INFORMATION VIA EMAIL AT **PRIVACY.ZURICH.CANADA@ZURICH.COM**OR YOU CAN REVIEW OUR PRIVACY STATEMENT AT [**HTTPS://WWW.ZURICHCANADA.COM/EN-CA/ABOUT-ZURICH/PRIVACY-STATEMENT**](https://www.zurichcanada.com/EN-CA/ABOUT-ZURICH/PRIVACY-STATEMENT) YOU MAY REFUSE TO CONSENT TO THE COLLECTION, STORAGE, USE OR DISCLOSURE OF PERSONAL INFORMATION; HOWEVER, THE REFUSAL TO PROVIDE CONSENT MAY RESULT IN **ZURICH CANADA** BEING UNABLE TO OFFER AND ADMINISTER INSURANCE COVERAGE OR PREVENT **ZURICH CANADA** FROM BEING ABLE TO PAY CLAIM BENEFITS. **ZURICH CANADA** IS COMMITTED TO PROTECTING THE PRIVACY AND CONFIDENTIALITY OF INFORMATION PROVIDED. YOUR FILE IS SECURED IN OUR OFFICES OR THOSE OF OUR ADMINISTRATOR OR AGENT. YOU MAY REQUEST TO REVIEW THE PERSONAL INFORMATION IT CONTAINS AND MAKE CORRECTIONS BY WRITING TO: **PRIVACY OFFICER, ZURICH INSURANCE COMPANY LTD (CANADIAN BRANCH), 100 KING STREET WEST, SUITE 5500, P.O. BOX 290, TORONTO, ON** **M5X 1C9.** FOR THE PURPOSES OF THE INSURANCE COMPANIES ACT (CANADA) THIS DOCUMENT AS ISSUED IN THE COURSE OF THE **ZURICH CANADA**’S INSURANCE BUSINESS IN CANADA. **CERTIFICATION**.  THE STATEMENTS I PROVIDE IN COMPLETING THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIMS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN THE EVENT OF A FALSE OR MISLEADING STATEMENT IN THE MAKING OF THIS CLAIM, COVERAGE CAN BE CANCELLED, PAYMENT OF BENEFITS DENIED AND PAST CLAIMS PAYMENTS RECOVERED. I AGREE TO REFUND TO THE INSURER, THE AMOUNT OF ANY PAYMENTS MADE IN THE EVENT THAT SUCH AMOUNTS SHOULD NOT HAVE BEEN PAID IN RESPECT OF MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. THIS AUTHORIZATION SHALL BE CONSIDERED VALID FOR THE DURATIONHE CLAIM, BUT NOT TO EXCEED ONE YEAR FROM DATE SIGNED. I HEREBY CONSENT TO THE COLLECTION, USE AND DISCLOSURE BY THE INSURER, ITS AGENTS AND ADMINISTRATORS OF MY PERSONAL AND HEALTH INFORMATION SET OUT HEREIN AND IN ALLDOCUMENTS OR INFORMATION PROVIDED IN CONNECTION WITH MY CLAIM TO PROCESS, INVESTIGATE AND SETTLE MY CLAIM. SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |