**This statement is to be completed by the Attending Physician. The Claimant is responsible for any fees associated with the completion of this form.**

Send the completed forms and all other required documents by mail to:

**Zurich Group Claims c/o Crawford & Company (Canada) Inc.**

**100 Milverton Drive, Suite 300, Mississauga, Ontario L5R 4H1**

**Fax: (905) 602-0185 / 1-877-364-6666**

**Email:** [**ZurichGroup@crawco.ca**](mailto:ZurichGroup@crawco.ca)

|  |  |  |  |
| --- | --- | --- | --- |
| **INFORMATION ABOUT THE PATIENT** | | | |
| **Full Name of Deceased/Patient:** | | | |
| **Date of Birth:** | | **Gender: Male  Female  Non-Identifying** | |
| **Address:** | | | |
| **City:** | **Province/State:** | **Postal/Zip Code:** | |
| **When did the accident occur (MM/DD/YYYY):** | | **When did the patient first consult you for this condition?** | |
| **Nature of Injury: Please explain in detail, including any/all diagnosis/dismemberment or loss of use, cause or incident causing this injury and all affected body parts.** | | | |
| **If injury resulted in the severance of a body part, please indicate the precise location of the severance:** | | | |
| **Did the injury result in the total and irrecoverable loss of hearing in both ears?**  **Yes  No** | | | **Date of Loss (MM/DD/YYYY):** |
| **Did the injury result in loss of sight?  Yes  No** | | | **If yes, was the loss total and irrecoverable?**  **Yes  No** |
| **Which eye was injured?  Right  Left** | | | **Was the eye removed?  Yes  No** |
| **Was the patient confined to a hospital?  Yes  No** | | | **If “Yes”, provide dates of confinement:** |
| **Name of Hospital of confinement:** | | | **Address:** |
| **Is the patient still under your care?  Yes  No** | | | **If discharged, provide date (MM/DD/YYYY):** |
| **If the incident resulted in death, provide date of death (MM/DD/YYYY):** | | | |
| **Place of death (if Hospital or Institution, please provide the name):** | | | |

|  |
| --- |
| **CAUSE OF DEATH** |
| **1. State the disease, injury or complication which caused death, not mode of dying, such as Heart Failure, etc.** |
|  |

|  |
| --- |
| **2. Antecedent Causes: Morbid conditions, if any, giving rise to the above cause stating the underlying cause last.** |
|  |
| **3. Other morbid conditions contributing to death, not related to the condition causing death.** |
|  |
| **4. To what extent did any antecedent causes contribute to death?** |
|  |
| **5. If death was due to an accident, suicide or homicide, specify which. Describe briefly and include dates.** |
|  |
| **6. Was an Inquest held?  Yes  No** |
| **Was an Autopsy performed?  Yes  No** |
| **If so, by whom and with what findings?** |
|  |
| **How was this death said to have been caused?** |
|  |
| **7. When and where did you first attend the Deceased for this matter?** |
|  |
| **8. Was the injury described above, directly and independently of all other causes, sufficient to produce death?** |
|  |
| **9. Have you treated or advised the Deceased during the last 3 years?  Yes  No** |
| **Did the Deceased, to your knowledge, receive treatment during the last 3 years from any other Physician, or in any Hospital or Institution? Yes  No** |
| **If “Yes” to either question, please furnish the following:** |
| **Name:** |
| **Address:** |
| **Nature of Illness or Injury:** |
| **Date:** |
| **Name:** |
| **Address:** |
| **Nature of Illness or Injury:** |
| **Date:** |

**The answers I have made to the above questions are true and complete to the best of my knowledge and belief.**

Name of Physician completing this form (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Office Address:** | |
| **Phone #: ( )** | **Fax #: ( )** |

|  |
| --- |
| **CERTIFICATE OF AUTHORIZATION** |
| Zurich Insurance Company Ltd. (Canadian Branch),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 insurance policy, providing customer service and assessing and paying claims.  I/We authorize any licensed Physician, medical practitioner, Hospital, clinic, other medical facility or provider of health care, Insurer or reinsurer, provincial health insurance plan and employer(s) to provide Crawford & Company (Canada) Inc., and its representatives employed to assist in the administration of this claim, any information, including personal information, data or records that are in their possession/knowledge regarding my medical history and treatment.  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. **Special GHIP direction (if the claimant is a child, this section applies to a parent or legal guardian).**  I/We direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to Crawford & Company (Canada) Inc directly, and I release GHIP, upon payment to Crawford & Company (Canada) Inc., from any further claim or cause of action in connection herewith.  I consent to the disclosure by GHIP to Crawford & Company (Canada) Inc., of such personal information as may be necessarily required for processing of my claim, including details of any duplicate payment previously made directly to me.  I consent and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to section 39(1) of the freedom of information and protection of privacy act, and to section 4(2)(f) of the health insurance act.  For Ontario residents only: I acknowledge that the information collected and used by OHIP on this form and related to any claims for which I am entitled to payment by OHIP is collected for the purposes of assessing my claim, processing payment therefore and any related purposes in accordance with section 4.1(1) and 1.1(2) of the Health Insurance Act.  I/We authorize Crawford & Company (Canada) Inc., to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I/We hereby irrevocably direct Crawford & Company (Canada) Inc., to make any payments, receive payments and settle with other carriers on my behalf.  **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 Insurance Company Ltd. (Canadian Branch)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 Canadaprivacy 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**](mailto: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 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 duration of the claim, but not to exceed one year from the 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 all documents or information provided in connection with my claim to process, investigate and settle my claim.  SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |