



Accidental Injury or Sickness

HOW TO FILE A CLAIM

1. Complete all items on the attached claim form.
2. Attach the following documents (as applicable):
 - Fully completed Attending Physician Statement (Required for all claims)
 - Copies of all police reports, newspaper articles, etc. describing accident
 - Copies of any additional documents that support your claim, including application and result of application for WCB, Employer Group, or EI benefits
 - Proof of Earned Income for the period immediately preceding the date of claim
3. Send the completed and signed claim form and all required documents to:

**Crawford Adjusters Canada
180 King Street, 4th Floor
Waterloo, Ontario N2J 1P8
Attention: New Claim**

4. Retain a copy for your records.

**YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL
INFORMATION OR DOCUMENTATION IS REQUIRED.**

**IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE
CALL Crawford Adjusters Canada at +1 (877) 597-8990**



Accidental Injury or Sickness Claim

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name _____ Date of Birth ___/___/___ Marital Status _____

Insured's Address _____ Phone No. (H) _____

Email address _____

Policy Number (Required) _____ Insured's Occupation _____

Regular Employer's Name _____

Employer's Address _____

Employer's Phone No. _____ Weekly Earnings: _____ Date Last Worked _____

Did the insured have any other insurance? _____ If yes, please list all companies, type of insurance, policy numbers and insurance amounts, including workers compensation and any other government plans: _____

CLAIM INFORMATION

Date of incident ___/___/___ Time and place incident occurred _____

Please describe in detail the circumstances of incident (attach separate sheet if needed): _____

Was the incident related to the Insured's regular occupation or their fire department activities, and if so how? _____

Please describe the nature of Insured's injuries or illness: _____

Please list the names and addresses of all treating physicians and hospitals: _____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

Claimant was a member of your organization at the time of the injury or illness? Yes No

Were they engaged in an authorized fire department activity at time of injury or illness? Yes No

Policy #: _____

Fire/Rescue/Ambulance Company/District Name: _____

Fire/Rescue/Ambulance Company/District Address: _____

Phone No. (W) _____

Print Name and Title _____ Signed _____ Date _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, and its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I also authorize Chubb to release information regarding the status, progress, or outcome of this claim to the Producer or Broker/Agent for this policy. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____ DATE ___/___/___