



Proof of Loss – Student Accident Insurance

Please answer all questions fully – it helps us to provide better service.

Instructions: Insured Student complete Claimant Statement Section; School Administrator complete School Declaration at bottom of page 1. Attending Physician complete Physician Statement Section on page 2.

Important: If Injury involves teeth, please complete Accidental Dental Claim Form. If the Member is covered under any other Medical insurance plan, the expenses must be submitted to that plan. If there is any unpaid balance, please attach their Payment Statement. Please retain copies of receipts for your files, as originals will not be returned.

Note: This form can be completed in ink (please print), however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety, must be returned along with ORIGINAL medical receipts to AXA Assurances Inc. at any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5
2020 University Street, Suite 700, Montreal, Quebec H3A 2A5
645 – 7th Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Claimant's Statement

Policy Number: 9226003

1. Insured Person's Full Name _____ 2. Date of Birth D M Y

3. If Injured Person is a minor, give Full Name of Parent or Guardian
Address
Street City Province Postal Code

4. Is the Injured Person a Canadian resident? Yes No

5. What is the name of the school board and district _____

6. What was the date of the accident D M Y

7. Where did accident occur? _____

8. Describe injury _____

9. Describe fully how accident occurred _____

10. What was the date of first treatment by doctor D M Y

11. Full Name of Physician _____ Telephone No. ()
Address
Street City Province Postal Code

12. Give dates of treatment
At Home D M Y Office D M Y Hospital D M Y
At Home D M Y Office D M Y Hospital D M Y
At Home D M Y Office D M Y Hospital D M Y

13. Name of hospital if treated in hospital _____

14. Date treated in hospital D M Y

15. Do you have any other Hospital or Medical Insurance? Yes No
Plan Name/Policy Number _____

I certify to the best of my knowledge that the statements made above are true, correct and complete.

_____, () D M Y
Insured Person's Signature (or Signature of Parent or Guardian if injured member is a minor) Telephone Date
Complete Address
Street City Province Postal Code

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

School Declaration

1. Name of School _____

2. Complete Address
Street City Province Postal Code

3. Effective date of Student's coverage D M Y

School Official Signature Print Name Official Position/Title
Policy Number Telephone () Date D M Y

Attending Physician Statement SectionPolicy Number **9226003**

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1. Patient's Name _____ 2. Patient's Date of Birth D M Y _____
3. Diagnosis of present condition _____
 (a) Primary _____
 (b) Secondary (if applicable) _____
4. On what dates did you examine the patient? D M Y _____, D M Y _____, D M Y _____
5. To the best of my knowledge
 (a) Symptoms first appeared or accident happened D M Y _____
 (b) Patient has had same or similar condition? Yes No
 If "Yes", state particulars _____
6. If attended at hospital, name of hospital _____
 Admitted D M Y _____ Time _____ AM/PM
 Discharged D M Y _____ Time _____ AM/PM
7. If surgery performed, describe _____
8. If patient referred to you, give name of referring physician _____
9. Have you referred the patient to a specialist for additional treatments? Yes No
 If "Yes", please explain _____
10. Have you referred the patient for physiotherapy treatments? Yes No If yes, date such referral was made: D M Y _____
 Frequency and duration of physiotherapy treatments? _____
11. To the best of my knowledge, the patient has been totally disabled (unable to attend school)
 From D M Y _____ to D M Y _____ inclusive
12. If still disabled, what date should the patient be able to return to school? D M Y _____
 Or, if indefinite, what is the estimated number of weeks before such return _____ additional weeks.
 How long was or will the patient be partially disabled (able to attend part-time school)?
 From D M Y _____ to D M Y _____ inclusive

Physician's Name (Print)

Physician's Signature

Address

Street

City

Province

Postal Code

Telephone ()

Date D M Y

The patient is responsible for securing this form and for any charges made for its completion.