



# Initial Claim Report

Underwritten by: Chartis Insurance Company of Canada  
145 Wellington Street West • Toronto, Ontario M5J 1H8  
Phone: 1-800-461-8347 • Fax: 416-596-4067

**PLEASE COMPLETE  
THIS FORM IN FULL  
FOR PROMPT SERVICE**

## TO BE COMPLETED BY INJURED PERSON

Name: \_\_\_\_\_ Social Insurance Number \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Number: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M or F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gross Weekly Wage: \$ \_\_\_\_\_/wk

Employer Name \_\_\_\_\_ Full-time Occupation: \_\_\_\_\_ # of Yrs Worked at this job \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

### Please answer the next 3 questions in detail:

1) Exactly what activity of your organization were you involved in when injured or became ill? \_\_\_\_\_

2) How did the accident or illness occur? \_\_\_\_\_

3) Exactly what is your injury or illness? \_\_\_\_\_

Date of Accident: \_\_\_\_\_ 20\_\_\_\_ Occurred: \_\_\_\_\_  AM  PM

Give date of first day of full-time occupation missed due to above accident & illness: \_\_\_\_\_ 20\_\_\_\_

How many days hospitalized overnight? \_\_\_\_\_ Give date you are/were able to return to work \_\_\_\_\_ 20\_\_\_\_

Attending Physician: Dr. \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name	Address	Telephone #
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**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 Chartis Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. 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.

**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.

**AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder, an employer or an organization to which I provide services as an independent contractor) to release and exchange with Chartis Insurance Company of Canada, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim. **I agree that a reproduction of this authorization shall be as valid as the original.**

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

## TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

Policy Number \_\_\_\_\_ What type of Policy?:  Firefighter  Councilor  Non-Profit Volunteer  Other

Select which category the Injured person is insured as?  Member (Firefighter or Councilor)  Non-member  Spouse  Dependent

What activity was the injured person engaged in at the time of injury or sickness?  On Duty (Authorized)  Off Duty (Not-Authorized)

Insured Organization Name: \_\_\_\_\_ Address \_\_\_\_\_

Daytime phone #(\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Print name of Signing Official \_\_\_\_\_ Title \_\_\_\_\_

I hereby certify the above is true (Signature) \_\_\_\_\_ Date: \_\_\_\_\_