

Triton Insurance Company

1420-380 Wellington Street
London, Ontario N6A 5B5

Toll Free 800-285-8623 | Fax 877-772-2623 | insclaims@omf.com

Insured's Name: _____ **Claim Number:** _____

Account Number: _____

Disability Claim Form - Personal Information Authorization

I hereby authorize, consent, and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, employer, any workers compensation board, Employment and Social Development Canada or any other organization, institution, association or person that now has or may have in future any records or knowledge concerning me or my health, employment history, benefits paid or any related information to disclose to Triton Insurance Company, their authorized representatives and reinsurers, upon the request of Triton Insurance Company any such information that is material to the administration of my claim.

Information obtained in association with this authorization may be accessed by authorized individuals of Triton Insurance Company for the purposes of administration of my claim. Some of these individuals may be located outside of Canada. For Quebec residents, some of these individuals may be located outside of the province of Quebec. For more information regarding Triton Insurance Company's Privacy Policy, please refer to the Privacy of Personal Information Statement on our website.

This authorization shall be valid for the duration of the claim. I have the right to revoke this authorization by providing a signed and dated, written notice to the insurance company above. Once this authorization is revoked, protected health information subject to this authorization will not be used or disclosed except to the extent that this authorization has already been relied upon. A photocopy of this authorization shall be as valid as the original.

By signing and submitting this claim form on your own behalf, you give your consent to the collection, use and disclosure of personal information.

Signature _____ **Date** (mm/dd/yy) _____

NOTE: We will not request genetic test results and if received inadvertently, we will not use genetic test results to determine eligibility for coverage or to determine claim benefits.

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Disability Claim Form - Instructions

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- 1. Sign and date the Personal Information Authorization.
- 2. **If filing for Critical Illness**, the Insured's Section and Attending Physician's Section should be fully completed, signed, and dated **after** covered critical illness (certain cancers, heart attack, stroke) has been diagnosed.
- 3. **If filing for Total Disability Benefits**, the Insured's Section and Attending Physician's Section should be fully completed, signed, and dated **after** the initial 30 day waiting period has been met.
- 4. Your Loan Protection Insurance Application and most recent transaction history must be provided by the lender.

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- Depending on your Insurance Certificate, benefits vary, and additional claim information may be required.
- Your Insurance Certificate may provide a limited number of Monthly Disability Benefits. The Maximum Number of Monthly Total Disability Benefits is listed in the Schedule on your Insurance Certificate. The Maximum Number of Critical Illness payments is 12.
- It is important to submit fully completed, signed, and dated claim forms to avoid delays in processing your claim. Altered claim forms may not be accepted.
- Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal/medical information.

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Please return your completed claim form and supporting documents to us in one of the following ways:



Email: insclaims@omf.com

Please be sure to include your name and account number/claim number in the subject line of your email.



Upload online:

www.tritoninsurancecompany.ca



Mail: Triton Insurance Company
1420-380 Wellington Street
London, Ontario N6A 5B5



Fax: 877-772-2623

We are here to help!

Our Customer Solutions team is available to assist you
Monday through Friday, 8:00 am to 8:00 pm ET.



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Account Number: _____

Disability Claim Form			
Insured's Section - To be completed by insured.			
Mailing address	City	Province	Postal Code
Telephone number	Date of birth (mm/dd/yy)		
Employer's name or if self employed, please state	Employer's telephone number		
Employer's mailing address	City	Province	Postal Code
Please provide the following information for your primary doctor and all doctors who have provided treatment in the past 2 years. If additional space is needed, please provide on separate page.			
Name of primary doctor and telephone number	Date first contacted (mm/dd/yy)		
Name of additional doctor and telephone number	Date first contacted (mm/dd/yy)		
If filing for Critical Illness, complete this section:			
Date diagnosed with critical illness (mm/dd/yy)	Critical illness diagnosis		
If filing for Total Disability Benefits, complete this section:			
Date unable to work due to disability (mm/dd/yy)	Date last worked (mm/dd/yy)		
Is this disability due to an: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Accident			
If injury or accident, provide date (mm/dd/yy) and location disability occurred. _____			
Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date returned (mm/dd/yy)	
I affirm the information I have provided herein is accurate and complete.			
Signature _____		Date (mm/dd/yy) _____	

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Insured's Name: _____ **Claim Number:** _____

Account Number: _____

Disability Claim Form			
Attending Physician's Section - To be completed by attending physician. Completed without expense to the insurance company.			
If totally disabled, date patient unable to perform principal job duties		From (mm/dd/yy)	Through (mm/dd/yy)
Primary diagnosis			
Date of diagnosis (mm/dd/yy)		Initial date of visit (mm/dd/yy)	
All subsequent visit dates (mm/dd/yy)			
Surgery dates, if applicable (mm/dd/yy)		Hospitalization dates, if applicable (mm/dd/yy)	
Is the disability due to an <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Accident			
Date symptoms first appeared or accident occurred (mm/dd/yy)			
If pregnancy related, provide estimated date of delivery and list any complications			
If totally disabled: Approximate date patient will be able to return to work (mm/dd/yy) _____			
<input type="checkbox"/> 1-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7 months or longer <input type="checkbox"/> Never returning			
Name of physician referring patient to your office, if any		Date of referral (mm/dd/yy)	
Referring physician's mailing address		City	Province Postal Code
Attending physician's mailing address		City	Province Postal Code
Telephone number		Fax number	
Attending physician's printed name			
Signature of attending physician			Date (mm/dd/yy)

**IMPORTANT NOTICE FROM
FAIRSTONE FINANCIAL INC.
CONCERNING YOUR PENDING INSURANCE CLAIM**

You recently applied for credit disability or credit job loss benefits from one of our insurance providers. We wanted to take a moment to make sure you understand the process and are aware of the steps you need to take to ensure you receive your maximum benefit if your claim is approved.

Continue to Make Payments

Until your claim for credit insurance benefits has been reviewed and approved, you are responsible for making your monthly payments. Please do not fall behind on your loan payments while your insurance claim is pending. You will be notified by the Insurance Company as soon as a decision is made.

Our Commitment

The Insurance Company is committed to processing your claim as quickly as possible. It is important that you file your claim forms and all required documentation in a timely fashion because if the insurance company has to gather the missing necessary information, it could add to the time it takes to process the claim.

If your claim is approved, the Insurance Company will begin making the payments on your behalf effective from the date of your eligibility. This ensures you do not miss out on any insurance benefits while your claim is being processed. Payments will continue to be made for as long as you submit the required claim forms and documentation in a timely manner and qualify for benefits.

Loan Term and Benefits

If you have made one or more loan payments that were also covered by the Insurance Company, you may request a refund of those payments from Fairstone Financial Inc..

If you do not request a refund, any covered payments that you have made will be applied as advance payments on your loan and could result in the loan being paid off before the end of your loan term and/or before you have received all of your potential insurance benefits.

If you have any questions or would like to request a refund, we're here to help. Please reach out to your local Fairstone Financial Inc. branch.

Thank you.