**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

**1**

- ❑ 1. Sign and date the Personal Information Authorization.
- ❑ 2. Fully complete, sign, and date the Insured's Section **after** the initial 30 day waiting period has been met.
- ❑ 3. Attending Physician's Section should be completed, signed, and dated by your doctor **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.

**2**

- ☐ Depending on your Insurance Certificate's requirements, additional claim information may be required.
- ☐ Your Insurance Certificate may provide a limited number of Monthly Disability Benefits. The Maximum Number of Monthly Disability Benefits is listed in the Schedule on your Insurance Certificate.
- ☐ 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.

**3**

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.

Toll free:
800-285-8623

Chat:
www.tritoninsurancecompany.ca

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

**Account Number:** _____

| Disability Claim Form<br>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 |
| Date unable to work due to disability (mm/dd/yy) | | Date last worked (mm/dd/yy) | |
| Is this disability due to an: ❑ Illness ❑ Injury ❑ Accident<br>If injury or accident, provide date (mm/dd/yy) and location disability occurred.<br>_____ | | | |
| Have you returned to work? ❑ Yes ❑ No | | If yes, date returned (mm/dd/yy) | |
| 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 | | Date first contacted (mm/dd/yy) | |
| Doctor's mailing address | City | Province | Postal Code |
| Name of additional doctor(s) | | Date first contacted (mm/dd/yy) | |
| Doctor's mailing address | City | Province | Postal Code |
| ***I affirm the information I have provided herein is accurate and complete.***<br>**Signature** _____ **Date** (mm/dd/yy) _____ | | | |

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

**Account Number: _____**

| Disability Claim Form<br>Attending Physician's Section - To be completed by attending physician.<br>Completed without expense to the insurance company. | | | |
|---|---|---|---|
| Date patient unable to perform principal job duties due to total disability | From (mm/dd/yy) | Through (mm/dd/yy) | |
| Initial date of visit (mm/dd/yy) | | | |
| All subsequent visit dates (mm/dd/yy) | | | |
| Primary diagnosis | | | |
| Surgery dates, if applicable (mm/dd/yy) | Hospitalization dates, if applicable (mm/dd/yy) | | |
| Is the disability due to an ❑ Illness ❑ Injury ❑ Accident | | | |
| Date symptoms first appeared or accident occurred (mm/dd/yy) | | | |
| If pregnancy related, provide estimated date of delivery and list any complications | | | |
| Approximate date patient will be able to return to work (mm/dd/yy) _____<br>❑ 1-3 months ❑ 4-6 months ❑ 7 months or longer ❑ 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.