Assumption Life
Group Insurance

Reset

Out of Country Questionnaire

Policy: _____ Division: _____ Certificate: _____
First and last name of the person insured: _____
First and last name of the sick or injured person (if different from the person insured): _____
Date of birth of the sick or injured person: (DD/MM/YYYY) ____/____/_____
Relationship of the sick or injured person to the insured: ☐ Common-law spouse ☐ Dependent child under 21 years of age
☐ Married spouse ☐ Dependent child over 21 years of age

Please note that clear and accurate answers to ALL questions will expedite the settlement of claims. Also, please make sure to keep a copy of your supporting documents.

1. Is this claim for services required as the result of an accident or illness? ☐ Yes ☐ No
   Specify: _____
   _____
2. Location of accident or illness: _____
3. Date and time of accident or illness: _____
4. How did the accident or illness occur? (please describe) _____
   _____
   _____
   _____
5. Nature of injury or illness: _____
   _____
6. Name of attending physician: _____
   Address of attending physician: _____
7. Date of departure from Canada: (DD/MM/YYYY) ____/____/_____ Date of return to Canada: (DD/MM/YYYY) ____/____/_____
   Date of expected return to Canada at time of departure: (DD/MM/YYYY) ____/____/_____
8. Date of first medical treatment for this injury or illness: (DD/MM/YYYY) ____/____/_____
   Date of hospitalization: (DD/MM/YYYY) ____/____/_____
9. Do you have travel coverage with any other insurer and/or credit card insurance plan other than your provincial health plan? ☐ Yes ☐ No
   If yes, Name of carrier: _____
   Name of credit card insurance: _____
   Policy Number: _____
   Person(s) insured: _____

Authorization

(Please print name of patient)

I hereby authorize the release to Assumption Life of any and all information you have regarding _____ while he/she was under observation or treatment by you, including history, findings and diagnosis. A photocopy of the Authorization is to be considered as valid as the original.

_____ _____
Signature of the sick or injured person (parent or legal guardian if dependent is a minor) Date (DD/MM/YYYY)

I hereby certify that the information given herein is accurate and complete.

_____ _____
Signature of the insured (parent or legal guardian if dependent is a minor) Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
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