



SGC 102845

Instructions: For all claims you must complete and sign Part I - Personal Information & Authorization. If your claim is for **Medical, Dental, or Vision Care Expenses**, you must complete Part II and attach expense receipts. If you are claiming for **Weekly Disability Benefits**, you must complete Part III in full.

When you are first submitting ANY claim, please be sure that you also attach an **Accident Report Form** completed by your Work Placement Employer/Training Agency **AND** a copy of your "Work Placement OR Participant Agreement".

Part I Personal Information & Authorization

Your Name _____ Your Date of Birth _____ Sex _____

Your Present Address _____
No. Street City Province Postal Code

Home Telephone No. (____) _____

Spouse Yes _____ No _____ Your Occupation _____

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by ACE INA Insurance or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Dated _____ 20____ Signature of Training Participant _____

Part II For Medical, Dental, or Vision Care Expenses (Remember to complete Part I)

Nature of Injury for which claim is being made _____

Describe **How, When and Where** the Accident occurred _____

Date of first Treatment _____ 20____

Name and Address of Hospital _____

Date of Admission _____ Date Discharged _____

Are any of the expenses claimed covered under any other plan? (eg. spouse, parent, personal) Yes _____ No _____

If "Yes" please provide a) Insurance Company b) Policy Number c) Certificate Number

List expenses claimed under policy (attach receipts) _____

Do you expect any future expenses Yes _____ No _____

If "Yes" state type of expense and amount if known _____

Part III Weekly Disability Benefit Claim Information - Please see other side

Part III Weekly Disability Benefit Claim Information - Please complete in full and remember to complete Part I on the reverse side

Your Social Insurance Number _____

List Occupational Duties _____

Date of Injury causing present Disability _____ 20 _____

Date last worked _____ 20 _____

Are you now totally disabled and unable to work? _____

If you are still disabled,

When is the estimated date you will be able to resume light duty work _____ 20 _____

When is the estimated date you will be able to resume full time work _____ 20 _____

If you are partially disabled, what important duties are you able to perform? _____

Do you have any other disability or sick pay insurance? Yes ____ No ____

If yes, give name and address of the source, and indicate the weekly or monthly amounts _____
