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**B.F. LORENZETTI & ASSOC. INC.**  
 Courtiers d'assurances internationaux / International Insurance Brokers



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**ACCIDENT CLAIM REPORT**

GROUP POLICY HOLDER		POLICY NUMBER	CERTIFICATE NO.
INSURED'S FULL NAME	STREET ADDRESS	CITY	PROVINCE
DATE OF BIRTH	HEIGHT AND WEIGHT	MARITAL STATUS	TELEPHONE
OCCUPATION PRIOR TO DISABLEMENT	DUTIES	MONTHLY EARNINGS	WEEKLY EARNINGS
<b>1</b> Give Full description of injury or disease from which you are now suffering. If an injury, tell when, where and how it happened.		SICKNESS <input type="checkbox"/> INJURY <input type="checkbox"/>	
<b>2 A</b> Have you ever had this, or a similar condition, in the past?  <b>B</b> If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics		YES <input type="checkbox"/> Condition(s): _____  NO <input type="checkbox"/> Dates: _____	
<b>3 A</b> Give exact date when illness began, or injury occurred. <b>B</b> When did you first consult a physician for this condition? <b>C</b> When did you become totally disabled (unable to work)? <b>D</b> When were you able to again perform part of your occupational duties? <b>E</b> When were you able to again perform all your occupational duties? <b>F</b> If still totally disabled, when do you expect your disability to terminate?		<b>A</b> Date: _____ <b>B</b> Date: _____ <b>C</b> Date: _____ <b>D</b> Date: _____ <b>E</b> Date: _____ <b>F</b> Date: _____	
<b>4</b> Hospitals (Give complete names, addresses and dates of confinement.)	NAMES	ADDRESSES	FROM TO
<b>5 A</b> Give names, addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE
<b>B</b> Give name, addresses and telephone numbers of usual family physician.			
<b>6</b> What other accident, sickness or disability insurance do you carry and what organizations or companies have paid you indemnity for sickness or injury?	NAMES	ADDRESSES	BENEFITS
<b>7</b> What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics).			
<b>8</b> Names and addresses of Employers and length of employment with each?	NAMES	ADDRESSES	FROM TO

I hereby authorize any hospital, physician or other person who has attended me, or any employer, to furnish American Home Assurance Company or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Approved by: \_\_\_\_\_ Dated \_\_\_\_\_  
 \_\_\_\_\_ M.D. SIGN YOUR FULL NAME \_\_\_\_\_  
 ATTENDING PHYSICIAN

PHYSICIAN'S STATEMENT ON OTHER SIDE



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**ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM**

**ACCIDENT**

PATIENT'S NAME AND ADDRESS	AGE
<b>1 A</b> Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location)	
<b>B</b> Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>2 A</b> When did symptoms first appear or accident happen?	Date _____ Year: _____
<b>B</b> When did patient first consult you for this condition?	Date _____ Year: _____
<b>C</b> Has patient ever had same Or similar condition? If "Yes" state when and describe	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3 A</b> Nature of surgical or obstetrical procedure, If any (describe fully)	Date performed _____ Year: _____
<b>B</b> Charge to patient for this procedure including post-operative care	\$ _____
<b>C</b> If performed in hospital, give name of hospital	_____ Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/>
<b>4</b> Give dates of other medical (non-surgical) treatment, if any	Office _____ Home _____ Hospital _____ Nursing Home _____
<b>5</b> What other services, if any, did you provide patient? (Itemize, giving dates and fees)	
<b>6</b> Where registered private duty nurse (R.N.) Services necessary?	
<b>7</b> Is patient still under your care for this condition? If "No" give date your services terminated	Yes <input type="checkbox"/> No <input type="checkbox"/> Date _____ Year: _____
<b>8 A</b> How long was or will patient be continuously totally disabled? (Unable to work?)	From _____ Year:____ Thru _____ Year:____
<b>B</b> How long was or will patient be partially disabled?	From _____ Year:____ Thru _____ Year:____
<b>C</b> Was house confinement necessary? If "Yes" give dates	Yes <input type="checkbox"/> No <input type="checkbox"/> From _____ Year:____ Thru _____ Year:____
<b>9</b> To your knowledge, does patient have other health insurance or Health plan coverages? If "Yes" identify	Yes <input type="checkbox"/> No <input type="checkbox"/>

**REMARKS**

	DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
	STREET ADDRESS	CITY OR TOWN	PROVINCE	POSTAL CODE