



SEASON PASS INSURANCE CLAIM FORM

POLICY NO: 100001557

Claimant's Surname _____ Claimant's First Name _____

Complete Mailing Address _____

City _____ Province _____ Postal Code _____

Claimant's Date of Birth (DD / MMM / YYYY) _____ Telephone Number: () _____

Claimant's Cancellation Due To: SICKNESS INJURY

Details: _____

List of physicians consulted during your illness/injury:

Name & Address	Date Consulted (DD/MMM/YYYY)	Reason

Indicate Name & Address of all hospitals where you received treatment for your present illness/injury and the dates:

Name	Address	Dates (DD/MMM/YYYY)	
		To	From

Does your illness/injury prevent you from skiing? Yes No

If "YES", what date (DD/MMM/YYYY) do you expect to resume skiing? _____

If "NO", what date (DD/MMM/YYYY) were you able to resume skiing? _____

Date (DD/MMM/YYYY)

Claimant's Signature

AUTHORIZATION OF THE INSURED

To all physicians, medical professionals, hospitals, medical care institutions, pharmacies, insurers and employers.

You are authorized to provide Industrial-Alliance *Pacific* Life Insurance Company consumer reporting agencies, attorneys and independent claim administrators, acting on behalf of Industrial-Alliance *Pacific* Life Insurance Company's behalf with information concerning medical care, treatment or services provided on the Insured's behalf.

This information is to be used for evaluating my eligibility to receive benefits under the contract and this authorization shall be valid for the duration of my claim. I understand I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is as valid as the original. It is agreed that issuance of this form is not an admission of liability on the part of the Insurer.

Date (DD/MMM/YYYY)

Claimant's Signature
(or authorized person if other than Insured)

**PLEASE HAVE THE REVERSE SIDE OF CLAIM FORM COMPLETED BY ATTENDING PHYSICIAN
REMEMBER TO RETURN YOUR MEMBERSHIP CARD AND PASS WITH THIS COMPLETED CLAIM FORM**

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name

Patient's Age

Patient's Address

Date of first visit (DD / MMM / YYYY)

Date of last attendance (DD / MMM / YYYY)

Were you actively supervising this patient's care during the full period?

Yes No If NO, comment in remarks section below.

Frequency of visits Weekly Monthly Other (specify) _____

Diagnosis of present disabling condition

Additional conditions which might affect the disability

If condition is due to pregnancy, what is (or was) the expected date (DD/MMM/YYYY) of confinement

Date Hospitalized
(DD/MMM/YYYY)

Hospital Name & Address

If surgery performed:
Describe

Date of Surgery: (DD/MMM/YYYY)

If referred to you, give name of referring physician

To the best of my knowledge, the patient had been unable to participate in the sport of alpine skiing:

From: (DD / MMM / YYYY) To: (DD / MMM / YYYY) Inclusive

To the best of my knowledge symptoms first appeared or accident happened: (DD / MMM / YYYY)

Patient has same or similar condition

No Yes If "YES", state when (DD / MMM / YYYY) and describe

Remarks:

Physician's Name:

Specialty:

Physician's Address:

Telephone No:

Date

(DD / MMM / YYYY)

Signature of Physician

Date

(DD / MMM / YYYY)

Signature of Patient