

Preamble

The professional must do the following as soon as a claim is filed against him or her, or as soon as he or she becomes aware of any facts, circumstances or allegations that could lead to a claim:

1. Dial 1 866 906-2120 to open a file and obtain a number. This number must be entered in Section 1 below and included when sending documents, as mentioned at the bottom of this declaration.
2. Fill out this declaration and return it to us by email to the address mentioned at the bottom of this declaration.
3. Attach all documents that are relevant to this claim.

Section 1

1. Insured

Name of professional: _____ Member / permit number: _____

File No. _____ Date of first notice received by client:

Y	Y	Y	Y	M	M	D	D
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(received when your file was opened)

Date of loss (date of treatment):

Y	Y	Y	Y	M	M	D	D
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Clinic (name of clinic): _____

Address: _____

Telephone:

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Professional's contact information: _____

Email: _____

Telephone:

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 Telephone (office):

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2. Claim Details

Name of claimant or client named in claim: _____

Address: _____

Postal code: [| | | | | |] Email: _____

Telephone: [| | | | | | | |]

Claimant's lawyer (if applicable): _____

Name of lawyer's law firm (if applicable): _____

Address: _____

Postal code: [| | | | | |] Email: _____

Telephone: [| | | | | | | |]

Place of loss:

- Clinic
- At the claimant's home
- Other location. Please specify: _____

3. Circumstances (please summarize)

4. Claim Amount

Note: Please provide us with your estimate of the claim value if no amount has been claimed yet: \$_____

Date on which professional services resulting in or likely to result in a claim were rendered: [Y | Y | Y | Y | M | M | D | D]

Date on which you became aware of the claim or the possibility of a claim: [Y | Y | Y | Y | M | M | D | D]

5. Nature of Loss

Provide a chronological description of the facts and circumstances pertaining to the incident or claim (symptoms, examination, diagnosis, treatment, etc.).
Attach extra pages as needed.

Section 2

Do you believe yourself to be responsible? Explain: Yes No

List of attached documents

Please list the documents you have attached to this form

I certify that all information contained in this declaration and the supporting documents are true and genuine.

X _____ | A | A | A | A | M | M | J | J |
Signature Date

Per : _____
Name (Please print)

Authorization for communicating information

This declaration and the documents to be attached thereto will be sent by Beneva Inc. (hereafter referred to as Beneva) to the lawyer assigned to the file or the claims adjuster responsible for the investigation. Please note that under section 62.2 of the Professional Code (CQLR, c. C-26), you are obliged to inform the Ordre professionnel de la physiothérapie du Québec (OPPQ) of any declaration of loss that you file with Beneva with regard to your professional liability. If you so authorize us, Beneva will inform the OPPQ that you submitted a declaration.

Beneva disclaims all liability for any use that may be made by the OPPQ of the information sent to it with your approval.

By this signature, I authorize Beneva to transmit to the OPPQ secretary the information indicated in section 1, as well as certain information related to the settlement of the claim by Beneva, in particular the amount of the claim incurred and its details.

X _____ | A | A | A | A | M | M | J | J |
Signature Date

Per : _____
Name (Please print)

Important Note

Protection of personal information

At Beneva, protecting your personal information is a priority. To learn more about how we collect, use and communicate this information, see our Privacy statement.

Please return this form, a copy of the claimant's file and any other document related to this declaration by email to: courrier@beneva.ca

Note: Please include the file number in the email subject.