



The professional must carry out the following actions immediately upon becoming aware of an incident or a claim:

1. Call **1 866 906-2120** to open a file and obtain the file number. This number must be indicated below and used when sending documents.
2. Complete this form and attach all documents relevant to the claim.

**Section 1**

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**1. Insured**

Name of professional order: \_\_\_\_\_

Name of member: \_\_\_\_\_ Member/licence No.: \_\_\_\_\_

File No.: \_\_\_\_\_ Date of first notice received by client:          
(Obtained when the file was opened)

Date of loss (date of event):

Name of company (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Home phone:

Your contact information: \_\_\_\_\_

Work phone:           Email: \_\_\_\_\_

Cell phone:

**2. Claim details**

Name of claimant or client named in claim: \_\_\_\_\_

Address: \_\_\_\_\_

Postal code: [ | | | | | | | | | ] Email: \_\_\_\_\_

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

Claimant's lawyer (If applicable): \_\_\_\_\_

Name of law firm (If applicable): \_\_\_\_\_

Address (including postal code): \_\_\_\_\_

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

Email: \_\_\_\_\_

**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. **Attach extra pages as needed.**

**Section 2**

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Do you believe yourself to be responsible?

Yes  No

Explain:

**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 des technologues en prothèses et appareils dentaires du Québec (OTPADQ) 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 OTPADQ that you submitted a declaration.

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

By this signature, I authorize Beneva to transmit to the OTPADQ 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](mailto:courrier@beneva.ca)  
**Note:** Please include the file number in the email subject.