Phonak Loss Claim Form

Form 36

Audiologist/Dispenser Name:	
SHIP TO Account Number: _____ Phone number: ( ) _____ Company Name: _____ Address: _____City: _____ Province: _____ Postal Code: _____	**BILL TO** Account Number: _____ Phone number: ( ) _____ Company Name: _____ Address: _____City: _____ Province: _____ Postal Code: _____
Client Information Last Name: First Name: Date of Birth: __ __ /__ __ /__ __ __ __ DD MM YYYY	**Hearing Instrument Information** Model: Serial Number: Receiver/Tubing size: Custom Earpiece SN:
Claim Type (Required): ☐ FEDERAL PROGRAM ☐ REGIE ☐ CNESST ☐ WSIB ☐ WORK SAFE BC ☐ WCB-AB ☐ WCB-SK ☐ WCB-MB ☐ MANITOBA HEALTH ☐ WCB-YK ☐ WHS EAST COAST ☐ EASTERN HEALTH ☐ ODSP ☐ OTHERS OTHER	
Claim Number (Required):	

Please refer to the current Phonak Price and Policy for our warranty policy

Please have the user or responsible party read and sign the following statement:

"I _____, hereby state that the above information is true and accurate. I understand that should the lost instrument be found, the replacement unit I was issued must immediately be returned to Phonak Canada."

Signature:_____ Date: _____
DD MM YEAR

SIGN & FAX BACK TO:

905-677-7536 or
Toll-free: 1-800-814-5799