Local 183
Members' Benefit Fund

Policy No. SRG9134041

Long Term Care

Local 183
Members' Benefit Fund

Claim Application Form

Long Term Care

SUBMISSION INSTRUCTIONS:

- Member to complete and sign Claimant's Statement.
- Claimant to complete and sign Authorization Form.
- Please keep a copy of completed application package for your records to substantiate your claim.
- Policy No. SRG9134041.
- Send all original completed applications to:

Local 183 Trust Administration
1263 Wilson Avenue, Suite 205
Toronto, ON M3M 3G2
Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line: 1-888-790-3534
E-mail:
info@183membersbenefits.ca

AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200,
Toronto, Ontario, Canada M5J 0A8

Long Term Care Claimant Statement
L.I.U.N.A. Local 183 Policy # 9134041

This claim is for expenses incurred for the following type of care (check all that apply)

Home Health Care ❑ Family Care ❑ Other ❑

Name of Claimant Filing Claim (If other than Member): _____ Relationship: _____ Telephone Number ( ) - _____ - _____

Name of Member: _____ Policy No: _____

Address: _____ Birth Date: MM / DD / YY Male ❑ Female ❑

_____ Telephone No: ( ) - _____ - _____

Are you currently residing at the address listed above? Yes ❑ No ❑

If **"Yes"** with whom do you live? Alone ❑ With Spouse ❑ With Family ❑ Other ❑

If **"No"** Currently at: Nursing Home ❑ Assisted Family Facility ❑ Hospital ❑ Other ❑

Other Insurance Information: (Please attach an Explanation of Benefits from your other insurance for any services fees you are also claiming under this Long-Term Care insurance policy)

	YES	NO	INSURANCE CO.	POLICY/ GROUP NO.	PHONE NO.
HEALTH INSURANCE	❑	❑			( ) - -
OTHER LONG TERM INSURANCE	❑	❑			( ) - -
MEDICAL/HEALTH INSURANCE	❑	❑			( ) - -

Is there a Power of Attorney or Legal Guardian? Please attach a copy of legal documents Yes ❑ No ❑

Power of Attorney's Name _____

Address _____ Relationship/Title _____

_____ Phone No. ( ) - _____ - _____

Describe your current disabling condition: its cause and date you first required assistance

Is this claim the result of an accident ? Yes ❑ No ❑

_____

_____

_____

LIST THE PHYSICIAN(S) CONSULTED FOR THIS CONDITION: (IF NOT ENOUGH SPACE HERE PLEASE ATTACH A SECOND PAGE)

NAME:	ADDRESS:	PHONE NO.	DATES CONSULTED
		( ) - -	MM / DD / YY
		( ) - -	MM / DD / YY
		( ) - -	MM / DD / YY

IF YOU WERE RECENTLY CONFINED IN A HOSPITAL OR NURSING FACILITY PLEASE PROVIDE INFORMATION BELOW

NAME:	ADDRESS:	PHONE NO.	DATES CONSULTED
		( ) - -	MM / DD / YY
		( ) - -	MM / DD / YY
		( ) - -	MM / DD / YY

DO YOU HAVE A CARE MANAGER Yes ❑ No ❑ IF "YES" CARE MANAGER'S NAME _____

CARE MANAGERS PHONE NO. ( ) - - _____

AUTHORIZATION

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the insurer) to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other Insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. **CERTIFICATION:** The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim. **AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the data hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health Information and benefit payment Information about me or any other information or records about me in its possession that is requested while administering my claim.
I agree that a reproduction of this authorization shall be as valid as the original.

Members Signature _____ Date MM / DD / YY

Signature of Claimant _____ Date MM / DD / YY

FOR OFFICE USE ONLY
ADMINISTRATOR AUTHORIZATION
TO BE COMPLETED BY LOCAL 183 TRUST ADMINISTRATION

Member Name		Member I.D. No.	
Claimant Name		Relation to Member	
Claimant's Eff. Date		Claimant's Termination Date	MM / DD / YY
Amount of Cash Benefit $ / Day			
Administrator's Title			
Administrator's Signature		Date Signed	MM / DD / YY
Daytime Phone Number	( ) - -	Ext.	

THE FURNISHING OF FORMS SHALL NOT BE AN ADMISSION TO LIABILITY

MAIL TO:

LOCAL 183 TRUST ADMINISTRATION
1263 Wilson Ave. Suite 205
North York, Ontario M3M 3G2
Tel: 416-240-7487 or Toll Free: 1-888-790-3534

AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
www.aig.com

LONG TERM CARE - L.I.U.N.A.
CLAIMANT'S AUTHORIZATION TO OBTAIN INFORMATION

Name of Claimant: _____ Date of Birth: _____

I hereby authorize the following uses and disclosures of health information about me relevant to this claim only:

1. The health information that I'm authorizing to be used or disclosed consists of my medical records and medical history and other information that relates to:
   -the diagnosis of any physical or mental condition,
   -the treatment and prognosis of any physical or mental conditions, whether such treatment is in electronic or paper form
   This indicates, but is not limited to, information related to psychiatric or psychological conditions, prescription drugs, alcohol or drug abuse, and communicable or infectious conditions such as AIDS, or sexually transmitted diseases.
2. The following persons or entities are authorized to disclose health information about me, a doctor, medical practitioner, hospital clinic, or medical or medically related facility, pharmacy or pharmacy benefit manager, or any insurance or reinsurance company or any other organization, institution, or person having health information about me.
3. Health information about me may be disclosed to AIG Insurance Company of Canada and its affiliates, service providers, reinsurers, agents and representatives.
4. Health information about me may be used or disclosed to evaluate or process any claim for long term care insurance benefits or to service my long term care insurance coverage. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory and law enforcement entities.
5. AIG Insurance Company of Canada and its representatives are authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want AIG Insurance Company of Canada and its representatives to discuss your claim.)

   Print Name:_____ Phone Number: _____

   Print Name:_____ Phone Number: _____

   Print Name:_____ Phone Number: _____

6. I understand that:
   - If I do not sign this Authorization, AIG Insurance Company of Canada and its representatives may decline to pay any claim insurance benefits.
   - Although an authorization may generally be revoked by sending a written request to AIG Insurance Company of Canada and its representatives, there is no right to revoke this Authorization if my claim for benefits may be contested by AIG Insurance Company of Canada and its representatives or if AIG Insurance Company of Canada and its representatives has already relied and acted upon this Authorization.
   - A copy of this Authorization is as valid as the original.
   - I may retain a copy of this Authorization.
   - This Authorization expires when coverage under my long-term care insurance policy terminates.

Insured's Signature (or Power of Attorney) Printed Name Policy No. Date

Please mail this form and direct inquiries to:

Local 183 Trust Administration
1263 Wilson Ave., Suite 205
Toronto ON M5M 3G2
Telephone: 416-240-7480 or 1-888-790-3534

The furnishing of forms shall not be an admission of liability by the Company.