Local 183 Members' Benefit Fund

Policy No. CI9105655

Critical Illness - Loss of Hearing / Sight / Speech, Coma, Burns and Organ Transplant

Local 183
Members' Benefit Fund

Claim Application Form

Loss of Hearing / Sight / Speech, Coma, Burns and Organ Transplant

SUBMISSION INSTRUCTIONS:

- Complete Claimant's Statement
  (Completed and signed by Member or Power of Attorney).
- Physician's Statement to be completed and signed by your Physician.
- Include any supporting medical records (original required). Please keep a copy of complete application package for you records to substantiate your claim.
- Policy No. CI9105655.
- Send all original completed applications to:

Local 183 Trust Administration
1263 Wilson Avenue, Suite 205
Toronto, ON M3M 3G2

Tel: 416-240-7487
Toll Free Line: 1-888-790-3534

AIG Insurance Company Of Canada
c/o Local 183 Trust Administration
1263 Wilson Avenue, Suite 205
Toronto, Ontario M3M 3G2
Telephone: 416-240-7480

CLAIMANT'S STATEMENT
Critical Care – Policy No.: CI 9105655

1. a) Full name of the Claimant (Member or Spouse):____________________

   b) Residence: ____________________

   c) Occupation:____________________

2. Date of Birth (M/D/Y): ____________________

3. Dates Hospitalized (M/D/Y): From:____________ To:____________

4. Advise nature of illness and when and where symptoms first occurred: ____________________

   ____

5. a) Name and address of consulting physician(s): ____________________

   ____

   b) Name and address of family physician: ____________________

6. Have you ever been treated for this or a related/similar Illness? ☐ Yes ☐ No

   If Yes, provide date(s) first consulted and name and address of treating Physician(s):

   ____

   ____

   ____

7. Please advise names of any prescription medications you are presently taking:

   ____

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 date 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, benefit payment, employment or financial 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.

Signature:____________________Witness: ____________________

Address: ____________________ Telephone:____________ Date: ____________

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

AIG Insurance Company Of Canada
c/o Local 183 Trust Administration
1263 Wilson Avenue, Suite 205
Toronto, Ontario M3M 3G2
Telephone: 416 – 240-7480

PHYSICIAN'S STATEMENT
Critical Care - Loss of Hearing/Sight/Speech
Coma, Burns and Organ Transplant

Full name of Insured:____

Date of Birth (M/D/Y):______________________ Policy No. ______________________

In order for a claim to be considered under this Critical Care insurance policy, the following section must be completed and signed by the treating physician or surgeon and the policy definition(s) must be satisfied.

First date of treatment: M _______ D ______ Y _______

Full description of loss:

____

____

Please outline all treatment provided with regards to condition and attach a copy of all test results and consultation reports: ____

____

____

Please outline any scheduled surgery or corrective treatment and the dates for such treatment:

____

____

LOSSES: (Please complete section which pertains to the loss applicable)

VISION: Percentage of loss of eye sight:__________________% ☐ Left Eye ☐ Right Eye

Current visual acuity:____

Is loss permanent and irrecoverable? ☐No ☐Yes

____

HEARING: Percentage of hearing loss:__________________% ☐ Left Ear ☐ Right Ear ☐ Both Ears

Is loss permanent and irrecoverable?____________________________________

Did any disease or previous injury contribute to loss? ☐No, and if ☐Yes – Describe:

____

____

BURNS: Did your patient sustain cosmetic disfigurement of the surface of their body which is full thickness or third-degree burns covering 20% or more of their body? Please outline:

____

____

____

____

COMA: Please confirm that your patient is in a profound state of unconsciousness from which the individual cannot be aroused, even by powerful stimulation, and that such state has been consistent for a minimum of 96 hours.

☐ Yes ☐ No What forms of treatment were untaken to stimulate consciousness:

____

____

____

Do you expect your patient to become fully conscious or recover from this present state of unconsciousness and if so, please explain:

____

____

____

Confirm term of hospitalization. Provide hospital name, address and date of admission and discharge.

Name of Hospital	Address	Admission date	Discharge date

Names and addresses of other physicians or surgeons, if any, who attended claimant.

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____

____

Please provide below any other information that would be helpful in the assessment of your patient's claim.

____

____

____

____

____

Please provide copies of any specialist or hospital reports for our Medical Director's review.

Are you related to or in a business relationship with this patient? ☐ Yes ☐ No

***These statements are true and complete to the best of my knowledge and belief*.**

Name of Attending Physician:______________________________

Address:____

Signature of Attending Physician____________________ Date:____________

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