



# Local 183 Members' Benefit Fund



Policy No. CI9105655

Critical Illness - Multiple Sclerosis

# Local 183 Members' Benefit Fund

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## *Claim Application Form*

### **Multiple Sclerosis**

#### **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.**



**PHYSICIAN'S STATEMENT**  
**Critical Care - Multiple Sclerosis**

1. Full name of Insured: \_\_\_\_\_
2. Date of Birth (M/D/Y): \_\_\_\_\_ Policy No. \_\_\_\_\_

In order for a claim for Multiple Sclerosis to be considered under this Critical Care insurance policy, the policy definition must be satisfied.

As used in the policy the term "**Multiple Sclerosis**" means the unequivocal written diagnosis by a physician who is certified as a neurologist confirming at least moderate persisting neurological abnormalities, with impairment of function, but not necessarily confining to a wheelchair or bed.

**Please print or type all your answers.**

1. a) On what date did your patient first consult you for this condition? M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_  
b) How long has this person been your patient? \_\_\_\_\_  
c) Please describe the residual neurological deficits:  
\_\_\_\_\_  
\_\_\_\_\_  
d) How long have the neurological deficits persisted?  
\_\_\_\_\_  
e) By whom was the diagnosis made?  
\_\_\_\_\_

2. Please provide a copy of the MRI if available.

3. On what date was the patient advised of the diagnosis? M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_  
By whom?  
\_\_\_\_\_

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for their diagnosis.

Name of Physicians or Hospitals	Address	Date From	Date To
_____	_____	_____	_____
_____	_____	_____	_____

5. What other investigations have been performed?  
\_\_\_\_\_  
\_\_\_\_\_

6. On what date did your patient first have symptoms or episodes. M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

What were they?

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7. Is there a family history of multiple sclerosis disease?  Yes  No

Please provide details.

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

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**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: \_\_\_\_\_

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