LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

# CRITICAL ILLNESS
# Coronary Artery Bypass Graft

# LiUNA LOCAL 183
# MEMBERS BENEFIT FUND

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## CRITICAL ILLNESS - Coronary Artery Bypass Graft

**SUBMISSION INSTRUCTIONS:**

- Complete Claimant's Statement *(Individual diagnosed with the Critical Illness)* (Completed and signed by Member/Spouse/Dependent 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. CI9105655A.
- Send all original completed applications to:


**LiUNAcare Local 183**
1263 Wilson Avenue, Suite 205
Toronto, ON M3M 3G2

Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line: 1-888-790-3534
Email: info@liunacare183.com

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

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

1. a) Full name of the Claimant (Member/Spouse/Dependent):_____

   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.**

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c/o LiUNAcare Local 183
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Toronto, Ontario M3M 3G2
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# PHYSICIAN'S STATEMENT
## Critical Care - Coronary Artery Bypass Graft

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 policy definition must be satisfied.

As used in the policy the term **"Coronary Artery Bypass Graft"** means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass Graft must be made by a cardiologist and based on angiographic evidence of the underlying disease.

**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? _____

2. When did the patient first suffer symptoms or episodes of cardiovascular disease and what were they?

   M_____D ____ Y _____

   _____

   _____

3. By whom was the diagnosis made? _____

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. Please provide the following details pertaining to the insured's bypass surgery and if available please provide operative notes.

   a) Date of surgery. M _____ D _____ Y _____

   b) Which arteries were bypassed?

   _____

   _____

   _____

6. On what date did your patient first have symptoms or episodes of cardiovascular disease?

   M _____ D _____ Y _____

   Please provide details:

   _____

   _____

   _____

7. Please describe including dates, any predisposing disorders or risk factors your patient had for cardiovascular disease.

   _____

   _____

   _____

8. Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No

   Please provide details.

   _____

   _____

   _____

9. Please provide details of patient's tobacco use including amount per day and date last used.

   _____

   _____

   _____

10. 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:_____

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