LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

CRITICAL ILLNESS
Hearing/Sight/Speech, Coma, Burn & Organ

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

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

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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Toronto, Ontario M3M 3G2
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PHYSICIAN'S STATEMENT
Critical Care - Loss of Hearing/Sight/Speech, Coma, Burns or 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.

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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