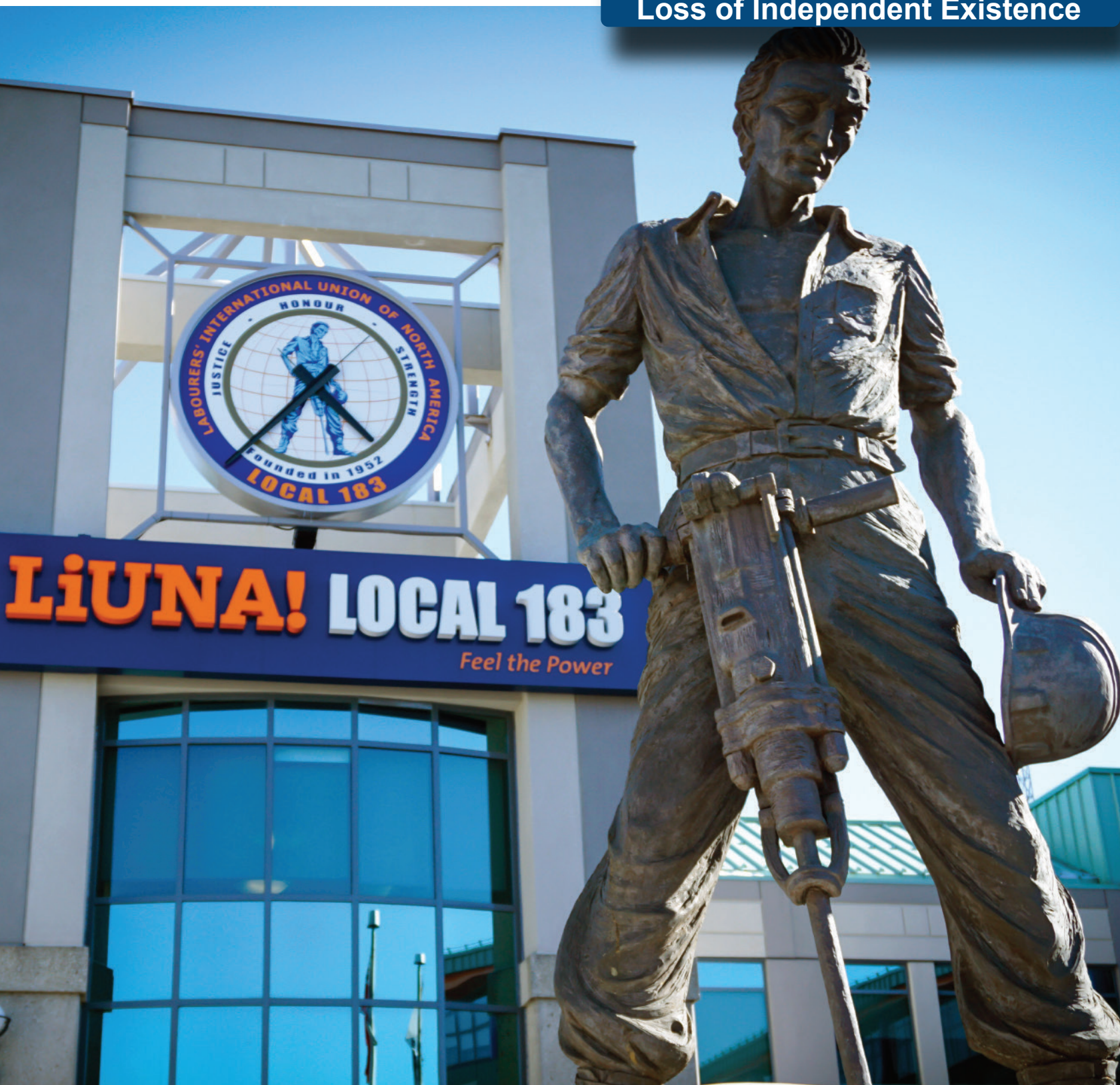
LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

CRITICAL ILLNESS
Loss of Independent Existence



LiUNA LOCAL 183
MEMBERS BENEFIT FUND

CRITICAL ILLNESS -
Loss of Independent Existence

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.

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

PHYSICIAN'S STATEMENT
Critical Care - Loss of Independent Existence

1. Full name of Insured:_____

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

In order for a claim for Loss of Independent Existences to be considered under this Critical Care insurance policy, the policy definition must be satisfied.

As used in the policy, the term **"Loss of Independent Existence"** is defined as a definite diagnosis of the total inability to perform, by oneself, at least 2 of the Activities of Daily Living (as described in section #7) for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a Physician.

Please note in order to meet the criteria for assessment of Loss of Independent Existence, your patient requires a current, complete assessment by an occupational therapist.

Please print or type all your answers.

1. Please provide a brief outline of the medical history leading to your patient's loss of independent existence.

_____

_____

_____

2. When did your patient first consult you for the underlying medical condition that has led to the loss of independent existence? Month _____Day _____Year _____

3. When did your patient first suffer symptoms of the medical condition that lead to the loss of independent existence? Month _____Day _____Year _____

4. Please provide the following:
   a. Details of exact extent of loss of function. _____
   _____
   _____
   b. The underlying cause of this condition. _____
   _____
   _____
   c. Details of cognitive function impairment, if any. _____
   _____
   _____

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

Physician/Hospital	Address	Dates of attendance
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. What other investigations have been performed?

_____

_____

_____

7. Please indicate if the patient is limited in any of the following Activities of Daily Living: (check all that are applicable)

- ☐ bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- ☐ dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- ☐ toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- ☐ bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- ☐ transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices;
- ☐ feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices;

8. Please provide 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.