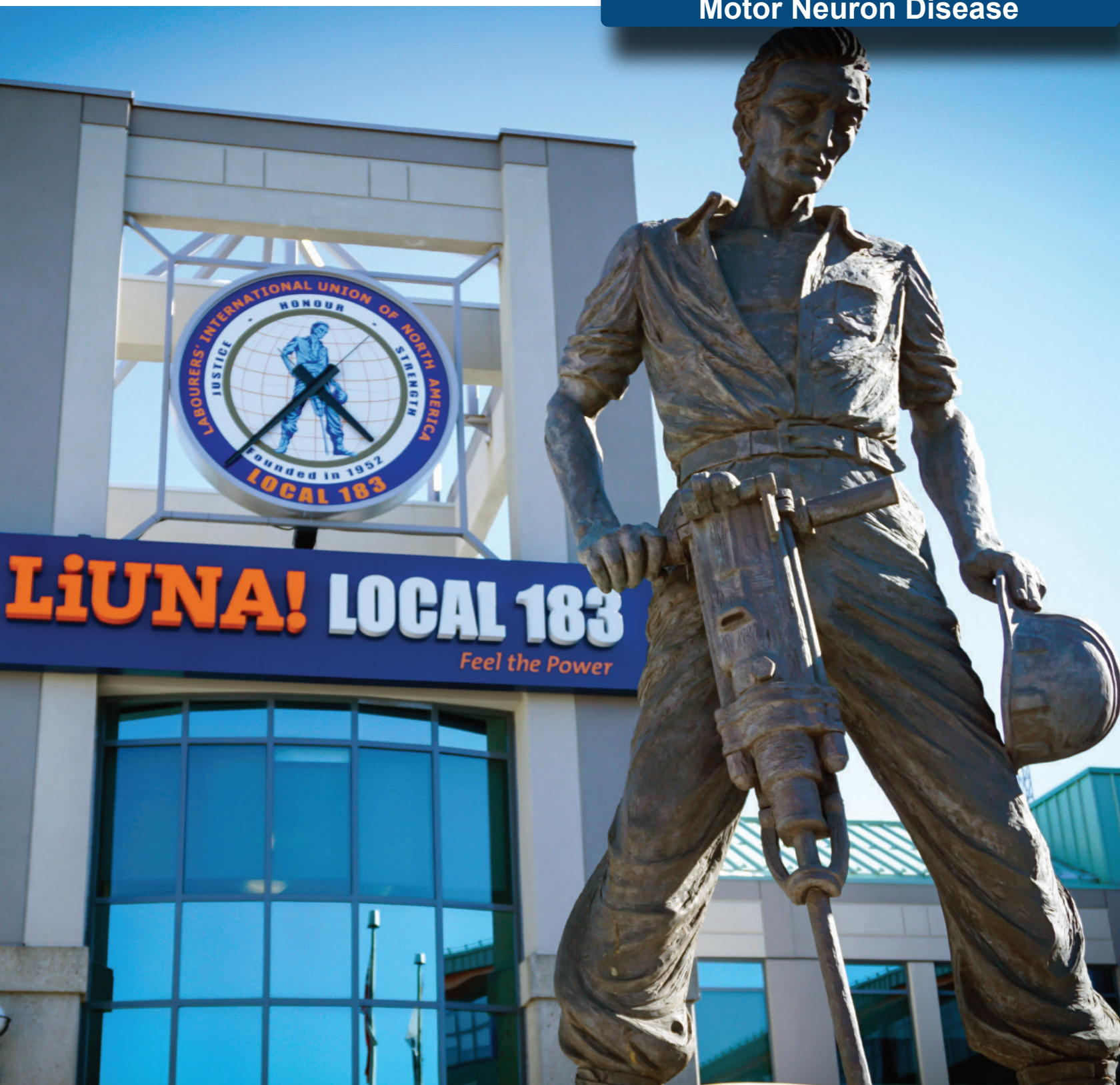
LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

CRITICAL ILLNESS
Motor Neuron Disease



LiUNA LOCAL 183
MEMBERS BENEFIT FUND

CRITICAL ILLNESS - Motor Neuron Disease

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 - Motor Neuron Disease

1. Full name of Insured:_____

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

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

As used in the policy the term **"Motor Neuron Disease"** means a definitive diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these entities.

A diagnosis of Motor Neuron Disease must be made by a Physician who is a certified neurologist.

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/EMG, 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 begin experiencing symptoms? M _____ D _____ Y _____
   Please list symptoms.

   _____

   _____

7. Is there a family history of this disease? ☐ Yes ☐ No
   Please provide details.

   _____

   _____

   _____

8. 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.