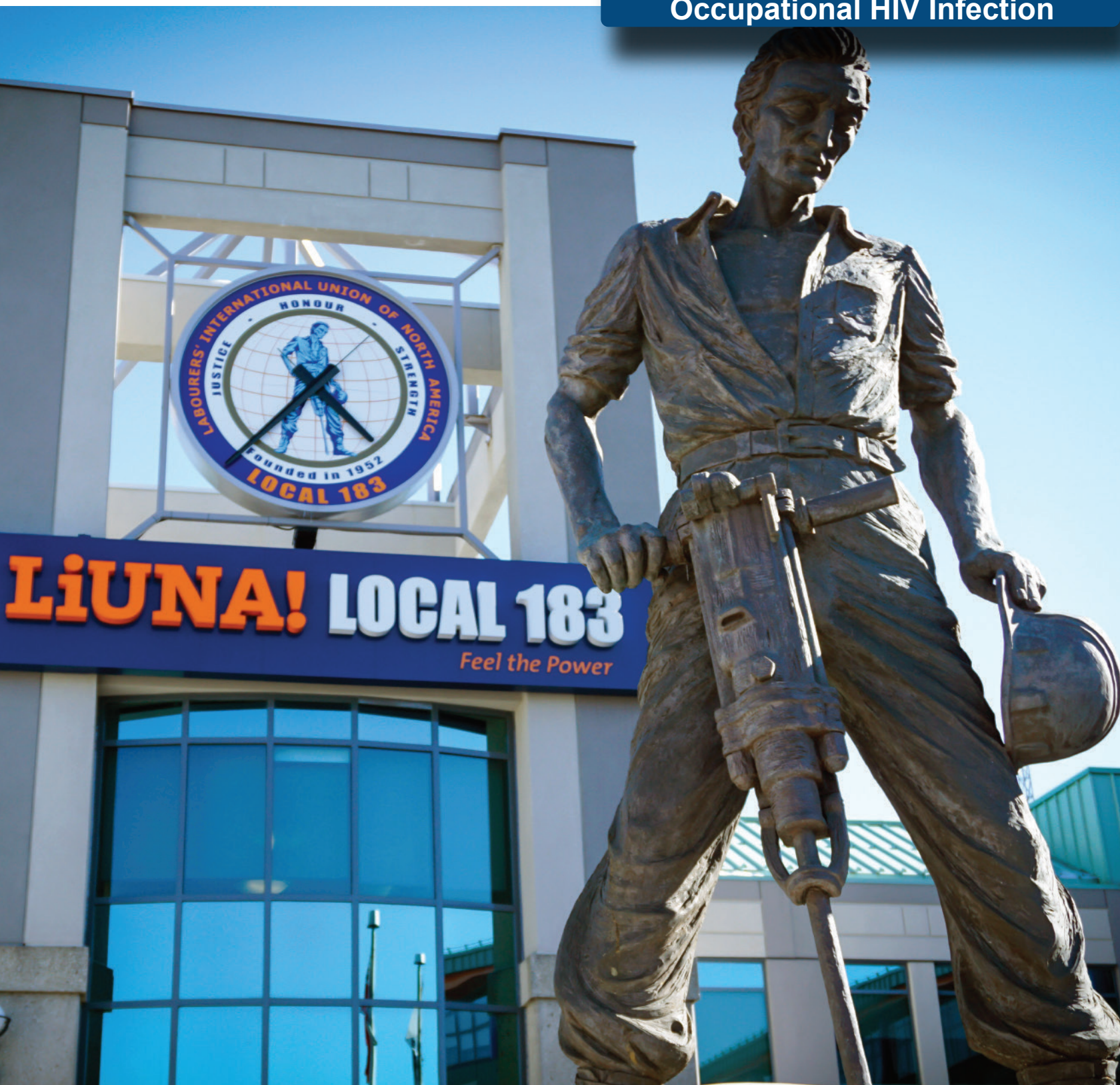
LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

CRITICAL ILLNESS
Occupational HIV Infection



LiUNA LOCAL 183
MEMBERS BENEFIT FUND

CRITICAL ILLNESS - Occupational HIV Infection

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 – Occupational HIV Infection

1. Full name of Insured:_____

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

In order for a claim for Occupational HIV Infection to be considered under the Critical Care insurance policy, the policy definition must be satisfied.

As used in the policy, the term **"Occupational HIV Infection"** is defined as a definitive diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The diagnosis of Occupational HIV Infection must be made by a Physician.

Please print or type all your answers.

1. How long has this person been your patient? Month _____ Day _____ Year _____
2. When did your patient first consult you for this condition? Month _____ Day _____ Year _____
3. On what date did your patient first suffer symptoms of this condition? Month _____ Day _____ Year _____
4. Please advise:
   a. Details and date of accidental injury leading to the infection. _____
   _____
   b. Symptoms? _____
   c. Date of definitive diagnosis. . Month _____ Day _____ Year _____
   d. Date of first serum HIV test taken following the accidental injury? Month _____ Day _____Year _____
   e. Was the first test result: ☐ Positive ☐ Negative
   f. Was a serum HIV test taken between 90 and 180 days after the accidental injury? ☐Yes ☐ No
   g. What were the results of these test results? ☐ Positive ☐ Negative
   h. Name and address of the licensed laboratory conducting testing. _____
   _____
   i. Please provide copies of all test results and investigations.
5. Please advise the most recent CD4 Count (AKA Tcell Count) _____
   _____(approx. 0-800)
6. Please provide copies of Viral Load Counts.
7. When were these last measured? Month _____ Day _____ Year _____
8. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this Occupational HIV Infection:

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

9. Outline of current medications: _____

10. Have medications changed recently, and if so, please provide explanation? _____

_____

11. Is the current medication therapy effective? ☐ Yes ☐ No Please outline side effects. _____

_____

_____

12. 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:_____

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