LiUNA!care LOCAL 183™
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

CRITICAL ILLNESS
Paralysis

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

CRITICAL ILLNESS - Paralysis

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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PHYSICIAN'S STATEMENT
Critical Care - Paralysis

1. Full name of Insured:____

2. Date of Birth (M/D/Y:_____________________________Policy No. ___________________________

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

As used in the policy the term Paralysis applies to Quadriplegia, Paraplegia, or Hemiplegia and means the total and irreversible paralysis of both upper limbs, paraplegia; total and irreversible paralysis of both lower limbs, or hemiplegia; total and irreversible paralysis of both limbs of one side of the body. Paralysis means the complete and irreversible paralysis of such limbs that last for a continuous period of 6 months or more from the date of diagnosis to determine that the paralysis is permanent .

Please print or type all your answers.

1. a) Please provide full description of injury sustained: and/or medical history leading up to patient's paralysis.

____

____

____

b) When did the patient first consult you for their condition? M _______ D ______ Y _______
c) On what date was the diagnosis made? M _______ D ______ Y _______
d) By whom was the diagnosis made?

____

2. Please provide the names and addresses of all physicians consulted or hospitals attended by your patient for their condition.

Name of Physicians or Hospitals	Address	Date From	Date To

3. Please provide the following details pertaining to the insured's paralysis:

a) What limbs are affected?

____

____

____

____

____

____

b) Full details of loss of function:

____

____

____

c) Are there any other underlying medical conditions?

____

____

____

____

d) What is the prognosis for recovery?

____

____

4. Would there be any treatment that might improve the condition? If yes, please advise.

____

____

5. 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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