LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

LONG TERM CARE

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

LONG TERM CARE

SUBMISSION INSTRUCTIONS:

- Member/Claimant to complete and sign Claimant Statement (pages 1 & 2).
- Claimant to complete and sign Claimant Authorization Form (page 3 & 4).
- Please keep a copy of completed application package for your records to substantiate your claim.
- Policy No. BC06127.
- 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

Long Term Care Claimant Statement
Local 183 Members' Benefit Fund – Policy BC06127

Name of Member: _____ Member No: _____

Member Telephone: _____ Date of Birth (MM/DD/YY): _____ Male ◯ Female ◯

Address of Member: _____

_____

Name of Claimant (if not Member): _____ Claimant Telephone: _____

Claimant's Relationship to Member: _____ Does Claimant reside with Member? Yes ◯ No ◯

Does Claimant live: Alone ◯ With Spouse ◯ Nursing Home ◯ Assisted Family Facility ◯ Hospital ◯ Other ◯

What is the **cause, condition or physical dependency** that required Claimant to seek long-term care services: _____

_____

Provide **the date that the Claimant first sought treatment for this condition** (MM/DD/YY): _____

Check all requiring assistance: Bathing ◯ Dressing ◯ Toileting ◯ Transferring ◯ Continence Care ◯ Eating ◯

List the Primary and Specialty Physician(s) consulted **for your disabling condition**:

Physician's Name	Address	Phone #	Date(s) Consulted
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you were recently confined in a hospital or nursing facility, list the details below:

Name of Facility	Address	Phone #	Dates Confined
_____	_____	_____	_____
_____	_____	_____	_____

Do you have a Care Manager? Yes ◯ No ◯ If Yes, Care Manager's Name: _____

Care Manager's Phone #: _____

ADMINISTRATOR AUTHORIZATION – TO BE COMPLETED BY LiUNAcare LOCAL 183 TRUST ADMINISTRATION

Member Name: _____ Member I.D. No: _____

Claimant's Name: _____ Relationship to Member: _____

Claimant's Effective Date: _____ Claimant's Termination Date: _____

Administrator's Signature:_____ Date Signed: _____

Administrator's Title: _____ Daytime Phone # _____

THE FURNISHING OF FORMS SHALL NOT BE AN ADMISSION OF LIABILITY BY THE INSURER.

AUTHORIZATION

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 Berkley Insurance Company, 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 coordinating 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 thirty-six months from the data 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 Berkley Insurance Company, or representatives thereof, all personal health information and benefit. I agree that a reproduction of this authorization shall be valid as the original.

Member's Signature _____ Date (MM/DD/YY) _____

Claimant's Signature _____ Date (MM/DD/YY) _____

POWER OF ATTORNEY

Is there a Power of Attorney or Legal Guardian? Yes ◯ No ◯

If Yes, please attach copy of Power of Attorney documents. Attached? Yes ◯ No ◯

Power of Attorney's Name: _____

Daytime Phone #: _____ Email: _____

Complete Mailing Address: _____

_____

Relationship to Claimant: _____

Local 183 Members' Benefit Fund – Policy BC06127
Claimant's Authorization to Obtain Information

Name of Claimant:_____

Member #: _____ Claimant's Date of Birth: _____

I hereby authorize the following uses and disclosures of health information about me relevant to this claim:

1. The health information that I'm authorizing to be used or disclosed consists of my medical records and medical history and other information that relates to:
    a. The diagnosis of any physical or mental condition;
    b. The treatment and prognosis of any physical or mental conditions, whether such treatment is in electronic or paper form.

    This indicates, but is not limited to, information related to psychiatric or psychological conditions, prescription drugs, alcohol or drug abuse, and communicable or infectious conditions such as AIDS or sexually transmitted diseases.

2. The following persons or entities are authorized to disclose health information about me, a doctor, medical practitioner, hospital clinic, or medical or medically related facility, pharmacy or pharmacy benefit manager, or any insurance or reinsurance company or any other organization, institution, or person having health information about me.

3. Health information about me may be disclosed to Berkley Insurance Company and its affiliates, service providers, reinsurers, agents and representatives.

4. Health information about me may be used or disclosed to evaluate or process any claim for long term care insurance benefits or to service my long term care insurance coverage. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory and law enforcement entities.

5. Berkley Insurance Company and its representatives are authorized to disclose health information about me to the individuals designated below. You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want Berkley Insurance Company and its representatives to discuss your claim.

Print Name _____ Phone Number _____

Print Name _____ Phone Number _____

Print Name _____ Phone Number _____

(CONTINUED ON NEXT PAGE)

6. I understand that:

    a. If I do not sign this Authorization, Berkley Insurance Company and its representatives may decline to pay any insurance benefits claimed by you.

    b. Although an authorization may generally be revoked by sending a written request to Berkley Insurance Company and its representatives, there is no right to revoke this Authorization if my claim for benefits may be contested by Berkley Insurance Company and its representatives or if Berkley Insurance Company and its representatives have already relied and acted upon this Authorization.

    c. A copy of this Authorization is as valid as the original.

    d. I may retain a copy of this Authorization.

    e. This Authorization expires when coverage under my long-term care insurance policy terminates.

Claimant's Name: _____ Member #: _____

Claimant's Signature (or Power of Attorney): _____

Date: _____

Please fax, email or mail this form and attachments, and direct all inquiries to:

LiUNAcare Local 183
1263 Wilson Avenue, Suite 205
Toronto, ON M5M 3G2
Telephone: 416-240-7480 or 1-888-790-3534

The furnishing of forms shall not be an admission of liability by the Insurer.