LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

LIFE INSURANCE
Special Needs Life Insurance

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

LIFE INSURANCE
Special Needs Life Insurance

SUBMISSION INSTRUCTIONS:

- Member to complete and sign the Claimant's Statement and Authorization Form.
- Attending Physician to complete and sign Physician's Statement.
- Include photocopy of Disability Tax Credit.
- Policy No. GL10363501. Please keep a copy of completed application package for your records to substantiate you claim.
- Send all 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

CHUBB

PROOF OF DEATH
CLAIMANT'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

PART A – INFORMATION ABOUT THE DECEASED

Policy No(s):		
Last Name:	**First Name:**	
Address:		
City:	**Province:**	**Postal Code:**
Place of Death:	**Cause of Death:**	

LIST THE COMPANIES WITH WHICH THE DECEASED HAD LIFE INSURANCE OR ACCIDENTAL INSURANCE

Company Name	Effective Date of Insurance	Amount of Insurance

LIST THE PHYSICIANS WHO ATTENDED TO THE DECEASED IN THE LAST TWO YEARS

Physician's Name	Address	Date of Visit	Reason for Visit

PART B – INFORMATION ABOUT THE CLAIMANT

Last Name:	**First Name:**		
Address:			
City:	**Province:**	**Postal Code:**	
Phone Number: ( )	**Your Social Insurance # (required for tax purposes):**		
You are claiming as (check one box only): ☐ **Beneficiary**	☐ **Estate's Executor**	☐ **Assignee**	☐ **Other**
If other, please specify:			
Date of Birth:			

PART C – DECLARATION & SIGNATURES

Claimant's Certification: The above statements 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 without refund of any premiums paid. 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.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, 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. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

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, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Signature_____ Date _____

CHUBB®

AUTHORIZTION TO OBTAIN INFORMATION (DECEASED)

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

Name of Insured: _____

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning the late

_____

to give to Chubb Insurance or Chubb Life Insurance Company of Canada all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance Company of Canada in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as

_____

and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance Company of Canada, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance Company of Canada requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this authorization shall be as valid as the original.

Name (Please Print) _____ Signature _____

Dated at _____ of _____
City/Town Region/Municipality

In the Province of _____ on this _____day

of _____.
Month and Year

Signature of Patent/Guardian if Child is a Minor _____

CHUBB

PROOF OF DEATH
PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

PART A – INFORMATION ABOUT THE DECEASED

Policy No:		
Last Name:	**First Name:**	
Date of Birth:	**Date of Death:**	
Address:		
City:	**Province:**	**Postal Code:**
Place of Death:	**Cause of Death:**	
Date of First Visit of the Last Illness:	**Date of Last Visit of the Last Illness:**	

Immediate cause of death (disease, injury or complication causing death) :	
Time between onset and death:	
List any other significant conditions whether or not related to the cause of death:	
Was death due to: ☐ **Accident** ☐ **Suicide** ☐ **Homicide** ☐ **None of the Above**	
Briefly describe:	
Was autopsy performed: ☐ **Yes** ☐ **No**	**Who performed the autopsy:**
What were the results of the autopsy:	

LIST THE TIMES THAT YOU ATTENDED TO THE DECEASED IN THE LAST TWO YEARS

Date of Visit	Nature of Illness

LIST THE TREATMENTS RECEIVED BY THE DECEASED IN THELAST TWO YEARS FROM OTHER PHYSICIANS, HOSPITALS OR INSTITUTIONS

Physician's Name	Address	Date of Visit	Nature of Illness

PART B – DECLARATION & SIGNATURES

I declare that these statements are complete and true to the best of my knowledge.

Name of Physician:	**Date:**	
Phone # of Physician: ( )	**Fax # of Physician: ( )**	
Address of Physician:		
City:	**Province:**	**Postal Code:**

Signature of Physician _____ Date _____

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION