LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

CRITICAL ILLNESS

Sight, Hearing, Speech, Limbs, Independent, Paralysis

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

CRITICAL ILLNESS

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
2100 - 200 Labourers Way
Vaughan, ON L4H 5H9
Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line: 1-888-790-3534
Email: lifeeventclaims@bpagroup.com

AIG c/o LiUNAcare Local 183
2100 - 200 Labourers Way
Vaughan, ON, L4H 5H9

CLAIMANT STATEMENT
Critical Illness

Name of Policyholder: **Policy No.:**

1. a) Full name of claimant:
   b) Address:
   c) Date of birth (*MM/DD/YY*):
   d) Full name of member (*if different*):
   e) Relationship to member: ☐ Spouse ☐ Common-Law ☐ Dependent Child
   f) Capacity in which claim is being made (*if applicable*): ☐ Beneficiary ☐ Executor ☐ Assignee ☐ Other (*explain*):
2. a) Nature of illness:
   b) Date of onset of symptoms (*MM/DD/YY*):
   c) Date of initial medical attention (*MM/DD/YY*):
   d) Have you ever been treated for this or related/similar illness or condition? ☐ No ☐ Yes (*provide*):

Name of Treating Physician(s)	*Address of Treating Physician(s)*	*Date (MM/DD/YY)*

   e) Were you hospitalized? ☐ No ☐ Yes (*provide*):

Name of Hospital(s)	*Address of Hospital(s)*	*Date From:*	*Date To:*

3. Name and address of consulting and family physicians:

	Name	*Address*
Consulting Physician(s):		
Family Physician:		

4. Names of any prescribed medications you are presently taking:

PERSONAL INFORMATION NOTICE AND CONSENT: 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, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside Canada for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.
CERTIFICATION: I declare that to the best of my knowledge and belief, the above particulars and the statements I provide in completing this claim form and otherwise in respect of my claims are true and accurate. I understand that any misrepresentation or omission of any material fact may result in denial of the claim, coverage may be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer the full amount of any payments made to me with respect to any claims of me or my dependents if it is determined that such amounts should not have been paid in respect of such claims, and agree that the Insurer may set off any such amount against any other benefits payable to me with respect to any claims of me or my dependents by the Insurer until the Insurer has recovered such amount in full.
AUTHORIZATION: I authorize, for a period of two (2) years 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 the group policyholder) to release and exchange with, and my employer to release and disclose to, the Insurer, or representatives thereof, all personal health information and benefit payment 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 if it were the original.

Signature: Date (*MM/DD/YY*): Phone number:

Address:

Email: Witness:

The furnishing of forms shall not be an admission of liability by the AIG Insurance Company of Canada.

AIG c/o LiUNAcare Local 183
2100 - 200 Labourers Way
Vaughan, ON, L4H 5H9

PHYSICIAN STATEMENT
Critical Illness – Blindness, Deafness, Loss of Speech, Loss of Limbs, Loss of Independent Existence, Paralysis, Severe Burn

In this Physician statement, "you" and "your" mean the Physician who completes it; "we", "us" and "our" mean AIG Insurance Company of Canada, the insurer providing **Critical Illness** *coverage.*

THE CLAIMANT IS RESPONSIBLE FOR ANY CHARGE INCURRED FOR COMPLETION OF THIS FORM.

1. a) Full name of patient:
   b) Date of birth (*MM/DD/YY*):

2. a) Patient's condition: ☐ Blindness ☐ Deafness ☐ Loss of Speech ☐ Loss of Limbs
   ☐ Loss of Independent Existence ☐ Paralysis ☐ Severe Burn
   b) Is this condition a direct result of an accident? ☐ No ☐ Yes (*provide*):
   Date of accident (*MM/DD/YY*): Place of accident:
   Date of first attendance (*MM/DD/YY*): Date loss was diagnosed (*MM/DD/YY*):
   c) Is this condition a direct result of an underlying medical condition? ☐ No ☐ Yes (*provide*):
   Underlying condition(s) that caused the loss (*full diagnosis including any complications*):

   Date of onset of clinical manifestations of underlying condition(s) (*MM/DD/YY*):
   d) Name of physician who made diagnosis: Specialty:
   g) Names and addresses of physicians consulted and/or hospitals attended by patient for this condition:

Name of Physician/Hospital	*Address of Physician/Hospital*	*Date From:*	*Date To:*

   h) How long has this person been your patient?

3. **Please complete a section below pertinent to your patient's condition:**

Blindness

   a) Did patient lose sight? ☐ No ☐ Yes, right eye ☐ Yes, left eye
   b) Date of loss (*MM/DD/YY*):
   c) Patient's current corrected visual acuity: Right eye: Left eye: Both eyes:
   d) Patient's current field of vision: Right eye: Left eye: Both eyes:
   e) Is this loss of vision total and irreversible? ☐ No ☐ Yes
   f) Please enclose copies of medical records supporting diagnosis (diagnostic test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

Deafness

a) Did patient lose hearing? ☐ No ☐ Yes, right ear ☐ Yes, left ear

b) Date of loss (*MM/DD/YY*):

c) Patient's current auditory threshold: Right ear: dB Left ear: dB Both ears: dB

d) Is this loss of hearing total and irreversible? ☐ No ☐ Yes

e) Please enclose copies of medical records supporting diagnosis (Audiogram test results, diagnostic test results, etc.)

Loss of Speech

a) Did patient lose speech (*ability to speak for a period of at least 180 days*)? ☐ No ☐ Yes

b) Date of loss (*MM/DD/YY*):

c) Is this loss of speech total and irreversible? ☐ No ☐ Yes

d) Was the loss caused by a psychiatric disorder? ☐ No ☐ Yes (*specify*):

e) Please enclose copies of medical records supporting diagnosis (diagnostic test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

Loss of Limbs

a) Please indicate limb(s) that patient has lost:

Hand(s):	☐ Right, at/above wrist joint	☐ Right, below wrist joint
	☐ Left, at/above wrist joint	☐ Left, below wrist joint
Foot/Feet:	☐ Right, at/above ankle joint	☐ Right, below ankle joint
	☐ Left, at/above ankle joint	☐ Left, below ankle joint

b) Date of loss (*MM/DD/YY*):

c) Please enclose copies of medical records supporting diagnosis (diagnostic test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

Loss of Independent Existence

a) Did patient lose ability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living (ADLs) for a continuous period of at least 90 days with no reasonable chance of recovery?

☐ No ☐ Yes (*indicate ADLs that patient has been unable to perform without assistance of another person for at least 90 days*):

- ☐ Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices
- ☐ Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices
- ☐ Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices
- ☐ Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained
- ☐ Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices
- ☐ Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices

b) Is this loss of independent existence total and irreversible? ☐ No ☐ Yes

c) Please enclose copies of medical records supporting diagnosis (diagnostic test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

Paralysis (Quadriplegia, Paraplegia, Hemiplegia)

a) Was patient diagnosed with paralysis? ☐ No ☐ Yes (*indicate*):

b) Date of diagnosis (*MM/DD/YY*):

c) Type of paralysis: ☐ Monoplegia ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia

d) Affected limbs: ☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

e) Full details of loss of function:

f) Is paralysis total and irreversible? ☐ No ☐ Yes

g) Is there any surgery or treatment that might improve patient's condition? ☐ No ☐ Yes (*explain*):

h) Please enclose copies of medical records supporting diagnosis (diagnostic test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

Severe Burn

a) Was patient diagnosed with third-degree burns? ☐ No ☐ Yes (*indicate*):

b) Date of diagnosis (*MM/DD/YY*):

c) Percentage of total body surface area covered in burns:
☐ Less than 20% ☐ 20% ☐ More than 20%

d) Please enclose copies of medical records supporting diagnosis (ER report, discharge summary, operative report, consultation / progress notes, etc.)

4. Please provide any other information that would be helpful in assessment of this claim:

These statements are true and complete to the best of my knowledge and belief.

By signing below, you confirm that you understand and agree that the information you provide on this form becomes part of the patient's Critical Illness file and that we may share that information with affiliates of AIG Insurance Company of Canada, the beneficiary or beneficiaries, applicable reinsurers, authorized third parties, including without limitation, third party service providers, and, where authorized by law, government entities, including financial services regulatory bodies and with other insurance companies to allow them to administer insurance with respect to the patient. Disclosures of information on this form will occur in accordance with AIG Canada's Privacy Principles available at www.aig.ca

Name of Attending Physician:

Address:

Signature of Attending Physician: Date (*MM/DD/YY*):

Phone number: Fax number:

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