LiUNA!care
LOCAL 183™
BUILDING HEALTHY FUTURES

Members Benefit Fund | Construction Division

# CRITICAL ILLNESS

## Other Eligible Critical Illnesses


Policy Nº - CI9105655

LiUNA!care LOCAL 183
MEMBER HEALTH MANAGEMENT SERVICES

Member Health Management Services
200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: memberhealthservices@liunacare183.com | liunacare183.com

# Critical Illness Benefit

If you or your eligible dependent is diagnosed with a critical illness and are under the age of 70, you may be eligible to receive the Critical Illness Benefit.

## Eligibility Requirements

- You must be a Member or an eligible dependent with plan coverage on the date you are first diagnosed with a critical illness.
- You must be under the age of 70.
- You must be diagnosed by a licensed physician (M.D.) in Canada.
- You must be diagnosed with one of the Eligible Critical Illness Conditions - please refer to the benefit plan booklet for the list of Eligible Critical Illness Conditions.
- There are certain definitions, exclusions, and limitations – please refer to the benefit plan booklet for greater detail.

## Benefit

- If you have met the eligibility requirements, you or your eligible dependents may be eligible for the following benefits:
  - Member – A maximum benefit of $40,000.
  - Spouse – A maximum benefit of $15,000.
  - Dependent Child – A maximum benefit of $10,000.

## Application Instructions

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Claimant to complete and sign the Claimant Statement of the Critical Illness Application Form.
3. The Physician's Statement to be completed and signed by your Physician.
4. Include any supporting medical records.
5. Return the completed application to LiUNAcare Local 183 Member Health Management Services by

   Email: **memberhealthservices@liunacare183.com**
   Mail: **200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9**
   Fax: **416-240-7047**
   Questions: Email or call us at **416-240-2104** or **1-866-315-6011**

6. Keep a copy of the completed application for your records to substantiate your claim.

**AIG Insurance Company of Canada**
**c/o LiUNAcare Local 183**
Suite 5400 - 200 Labourers Way
Vaughan, ON, L4H 5H9
Telephone: 416-240-2104| Fax: 416-240-7047
E-mail: memberhealthservices@liunacare183.com

# CLAIMANT STATEMENT
## Critical Illness

**Policy No.:**

**Name of Policyholder:** **Union ID.:**

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 AIG Insurance Company of Canada.**

**AIG Insurance Company of Canada**
**c/o LiUNAcare Local 183**
Suite 5400 - 200 Labourers Way
Vaughan, ON, L4H 5H9
Telephone: 416-240-2104 | Fax: 416-240-7047
E-mail: memberhealthservices@liunacare183.com

# PHYSICIAN'S STATEMENT
## Critical Illness

Full name of Insured:_____

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

In order for a claim to be considered under this policy, the following section must be completed and signed by the treating physician or surgeon, and the policy definition must be satisfied.

First date of treatment: M _____ D _____ Y _____

Full description of loss/diagnosis:

_____

_____

Please outline all treatment provided with regards to condition and attach a copy of all test results and consultation reports:

_____

Please outline any scheduled surgery or corrective treatment and the dates for such treatment:

_____

Confirm term of hospitalization. Provide hospital name, address and date admitted:

_____

_____

Names and addresses of other physicians or surgeons, if any, who attended claimant:

_____

_____

_____

Please give 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 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:_____

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