AIG c/o LiUNAcare Local 506
3750 Chesswood Drive - Suite 1
North York, ON M3J 2W6

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 AIG Insurance Company of Canada.