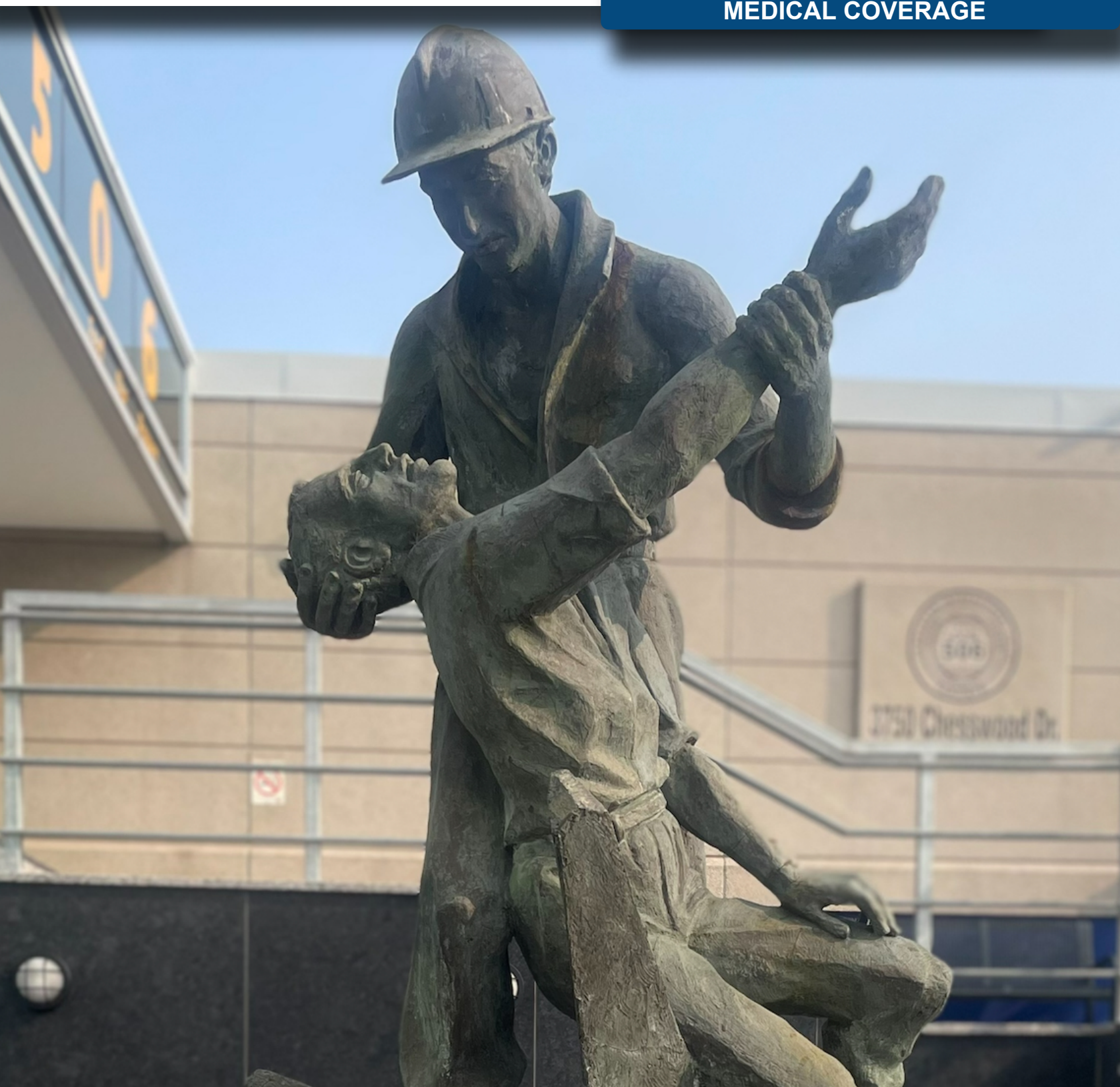
LiUNA!care
LOCAL 506
TM
BUILDING HEALTHY FUTURES

Labourers' Union Local 506
Members Benefit Trust Fund
ACTIVE MEMBERS

EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE



LABOURERS' UNION LOCAL 506
MEMBERS BENEFIT TRUST FUND
- ACTIVE MEMBERS -

EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE

SUBMISSION INSTRUCTIONS:

- Member to fully complete and sign the Emergency Out of Province Medical Coverage claim form.
- Include all receipts and invoices (originals required). Please keep a copy of completed application package for your records to substantiate your claim.
- Include copies of boarding passes & passport stamps indicating dates of travel.
- Policy No. SRG 9426170.
- Send all original completed applications to:

LiUNAcare Local 506
3750 Chesswood Drive, Suite 1
Toronto, ON M3J 2W6

Tel: 416-506-8841
Fax: 416-506-8833
Email: lifeeventclaims@bpagroup.com
Web: www.liunacare506.com

EMERGENCY MEDICAL CLAIM REPORT

Please answer all questions fully – it helps us to provide better service.
Important: Claims must be supported by a copy of the details of the claimant's other insurance carriers' settlement or denial, and a copy of all ORIGINAL bills showing the date and details of services rendered.
It is important that all questions on this claim report be answered - if any section is not applicable indicate n/a.
Please print in BLOCK LETTERS.

Note: This form must be completed, signed and dated. The **original** signed form in its entirety along with **original** supporting documents (e.g. invoices) must be returned to AIG Insurance Company of Canada's travel emergency assistance provider, **AXA Assistance Canada Inc.** at the following e-mail address:
ATTN: AIG Claims - aigclaims@axa-assistance.ca
Please also CC : lifeeventclaims@bpagroup.com

Should you have any questions on the claims process, you may call AXA Assistance Canada at : **1-800-411-0118**

Insured Information

1. Plan Member's Full Name .....
2. Date of Birth D M Y .....
3. Membership/Policy Number .....
4. Union/Member ID .....
5. Claimant's Name .....
6. Relationship to insured (if different) .....
7. Claimant's Date of Birth D M Y .....
8. Claimant's Email .....
9. Claimant's Mailing Address .....
10. Provincial Health Plan (OHIP) Number .....

Claim Details

1. What was the purpose of your trip? .....
2. Departure date from province D M Y .....
3. Return date to province D M Y .....
4. This claim is due to ☐ Injury ☐ Sickness (Describe how and where it happened)

.....

.....

.....

5. When did injury occur or symptoms of sickness first appear? D M Y .....
6. Where did injury occur or symptoms of sickness first appear (city/country)? .....
7. (a) Have you had same or similar condition before? ☐ Yes ☐ No If "Yes", provide details

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(b) Please provide names of physicians consulted for your previous condition *(if you answered "yes" to question 8. a)*

Name ..... Address .....
Diagnosis ..... Consulted: From/To .....
Name ..... Address .....
Diagnosis ..... Consulted: From/To .....

8. Were you hospitalized for your present condition? ☐ Yes ☐ No If "Yes", please provide the following:
Name and address of hospital:

.....

Dates of hospital confinement
From D M Y ..... to D M Y ..... || From D M Y ..... to D M Y .....

9. Name and address of your family doctor in Canada
Name ..... Telephone ( ) .....

Address .....

10. Is the claimant insured under a provincial health plan? ☐ Yes ☐ No - If "No", please provide an explanation

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Schedule of Expenses

(if space is insufficient, please continue on a separate sheet of paper)

Has Account Been Paid? Yes	No	Name of Provider	Date of Service (D/M/Y)	Total Bill	Paid By Provincial Health Plan	Paid by Other Insurance Carrier
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
			Totals			

Currency of the presented bills? ☐ CAD $ ☐ USD ☐ Other:

Coverage With Other Insurers

Do you have benefits available through any other Travel Insurance Company or Travel Supplier? ☐ Yes ☐ No

If yes, please provide the name and policy number: .....

If you have already submitted a claim, please provide the claim number: .....

Do you have a Bank Credit Card that offers travel benefits? ☐ Yes ☐ No

If yes, please provide the last 4 digits of the credit card: ..... Credit card type: .....

Name of Financial Institution: .....

If you have already submitted a claim, please provide the claim number: .....

I certify to the best of my knowledge that the statements made above are true, correct and complete AND:

1. I authorize you to provide AIG Insurance Company of Canada through its travel emergency assistance provider AXA Assistance Canada Inc. any and all information you have regarding me, relevant to my claim, including my medical history, diagnoses and test results, and I hereby consent to the disclosure of such information by AIG Insurance Company of Canada through its travel emergency assistance provider AXA Assistance Canada Inc. to other sources as may be required for the processing of my claim for benefits obtainable from other sources.

2. I hereby assign to AIG Insurance Company of Canada through its travel emergency assistance provider AXA Assistance Canada Inc. any benefits obtainable from other sources for losses covered under this policy. I also direct these sources to forward payment to AIG Insurance Company of Canada through its travel emergency assistance provider AXA Assistance Canada Inc. for my claim submitted with regard to these losses.

3. I understand my claim may be subject to review and investigation and I authorize AIG Insurance Company of Canada through its travel emergency assistance provider AXA Assistance Canada Inc. or their authorized agents authority to acquire any documents or statements from other insurers, financial institutions, travel suppliers, any company or public/private organization which can provide information related to my claim, and I hereby consent to the disclosure of such information by AIG Insurance Company of Canada through its travel emergency assistance provider AXA Assistance Canada Inc. to other sources as may be required for the processing of my claim.

Insured's Signature ..... Date D M Y ..... Telephone No. ( ) .....

Claimant's Signature ..... Date D M Y ..... Telephone No. ( ) .....

AUTHORIZATION AND RELEASE

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 .....

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.