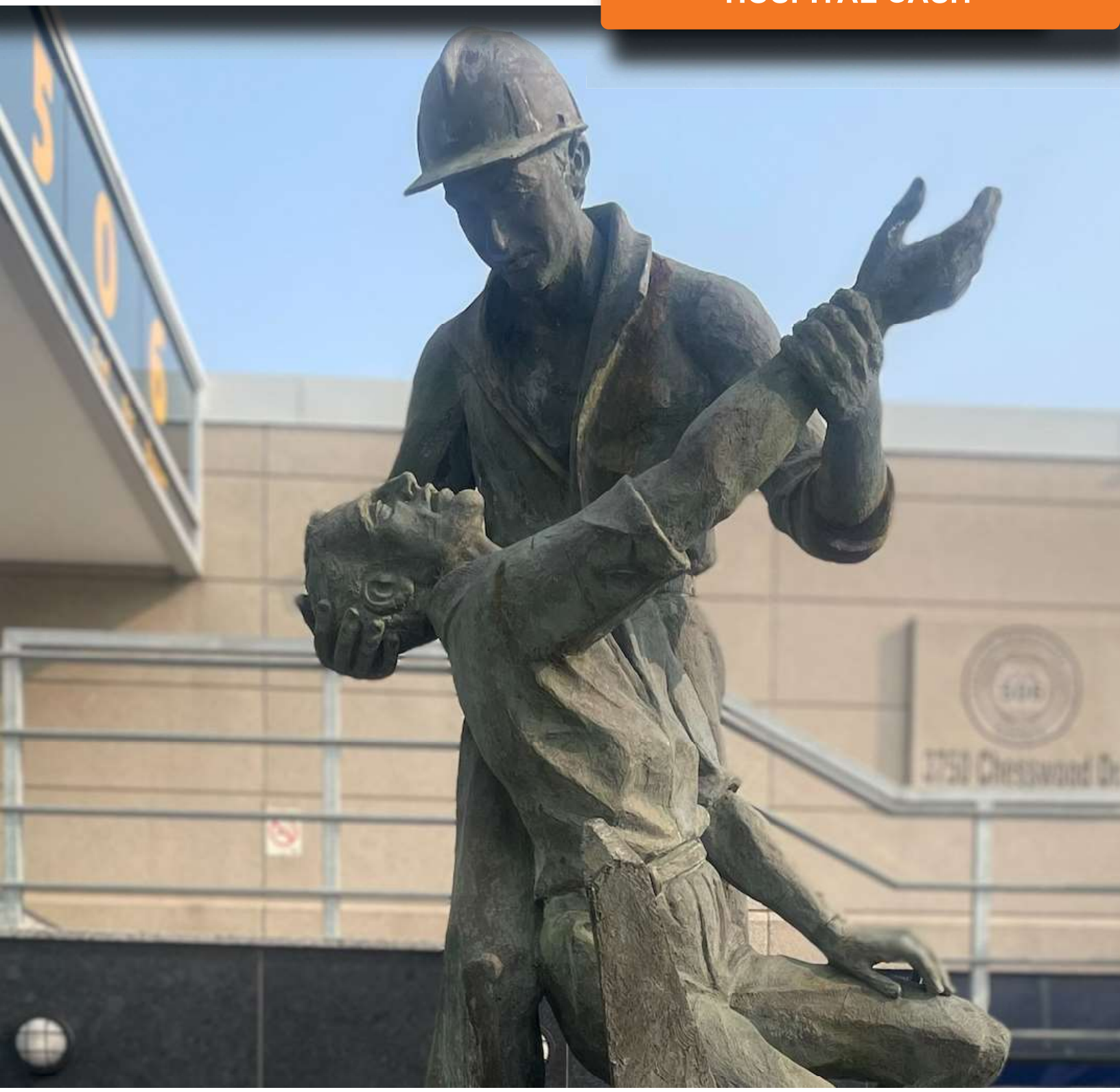
LiUNA!care
LOCAL 506 TM
BUILDING HEALTHY FUTURES

Labourers' Union Local 506
Members Benefit Trust Fund
**RETIRED MEMBERS**

# HOSPITAL CASH



# LABOURERS' UNION LOCAL 506
# MEMBERS BENEFIT TRUST FUND
# - RETIRED MEMBERS -

---

## HOSPITAL CASH

**SUBMISSION INSTRUCTIONS:**

- Member to complete and sign the Hospital Cash benefit claim form;
- Include your hospital discharge summary indicating reason for hospitalization and diagnosis. Please keep a copy of completed application package for your records to substantiate your claim.
- Policy No. SG10395007.
- Send completed application and supporting documents via fax, email or mail to:


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

Tel: 416-506-8841
Fax: 416-506-8833
healthservices@liunacare506.com
Web: www.liunacare506.com

CHUBB

**HOSPITAL CASH BENEFIT**
**LABOURERS' UNION LOCAL 506**
**MEMBERS' BENEFIT TRUST**
**FUND POLICY NUMBER:**
**HC10395007 RETIREE**

Chubb Life Insurance Company of Canada
c/o LiUNAcare Local 506
3750 Chesswood Drive – Suite 1
North York, ON M3J 2W6
Telephone: 416-506-8841
E-mail:healthservices@liunacare506.com

## PLEASE KEEP IN MIND

- Missing or inaccurate information may result in delays. Please complete all sections accurately and sign.
- Attach required Hospital Documents.
- E-mail will be utilized if an e-mail address is provided in the claim form.
- If submitting claims for multiple confinements, please collate requirements per hospitalization.
- Retain a copy of all documents submitted.

## REQUIREMENTS

- Completed and Signed Hospital Cash Benefit Claim Form
  - Section A by the Member
  - Section B by the Plan Administrator

- Hospital Documents
  - *Hospital issued record of confinement (e.g., Admission and Discharge Record), OR
  - *Patient records available through online account
  - If available, the Hospital Invoice confirming admission and discharge dates

  **Must include patient name, admission and discharge dates, diagnosis and reason for hospital stay*

- Others
  - Power of Attorney for Property if Member or Claimant is unable to sign.

## QUESTIONS REGARDING CLAIM SUBMISSIONS?

**E-mail: healthservices@liunacare506.com**
**Mail:Chubb Life Insurance Company of Canada**
**c/o LiUNAcare Local 506**
**3750 Chesswood Drive – Suite 1**
**North York, ON M3J 2W6**

## WHERE TO SEND YOUR CLAIM?

**E-mail: healthservices@liunacare506.com**
**Mail:Chubb Life Insurance Company of Canada**
**c/o LiUNAcare Local 506**
**3750 Chesswood Drive – Suite 1**
**North York, ON M3J 2W6**

CHUBB

# HOSPITAL CASH BENEFIT
# LABOURERS' UNION LOCAL 506
# MEMBERS' BENEFIT TRUST
# FUND POLICY NUMBER:
# HC10395007 RETIREE

Chubb Life Insurance Company of Canada
c/o LiUNAcare Local 506
3750 Chesswood Drive – Suite 1
North York, ON M3J 2W6
Telephone: 416-506-8841
E-mail:healthservices@liunacare506.com

**PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT**

## SECTION A: TO BE COMPLETED BY MEMBER

**PLEASE PRINT AND INCLUDE ALL INFORMATION REQUESTED**

| | | |
|---|---|---|
| **Member Name:** | | **Gender: ☐ Male ☐ Female ☐ Non-Binary** |
| **Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ None ☐ Other** _____ | | |
| **Member I.D. No.:** | | **Primary Telephone No.: (  )** |
| **Date of Birth:** Month/Day/Year | | **Alternate Telephone No.: (  )** |
| **Street Number and Name:** | | **Apartment/Suite No.:** |
| **City:** | **Province:** | **Postal Code:** |
| **E-Mail :** | | |
| **Employer Name:** | **Union/Local:** | |

**IF CLAIM IS FOR DEPENDENT, PLEASE PROVIDE THE FOLLOWING:**

| | | |
|---|---|---|
| **Dependent's Name:** | | **Gender: ☐ Male ☐ Female ☐ Non-Binary** |
| **Relationship to Member:** | | **Date of Birth:** Month/Day/Year |
| **Dependent's Address (if different from Member):** | | |
| **City:** | **Province:** | **Postal Code:** |
| **Dependent's Telephone No.:** | **Dependent's E-Mail:** | |

**Note: An eligible insured must be hospitalized for a minimum of 72 hours to be eligible to receive the hospital cash benefit. Hospital stays less than 3 days do not qualify for this benefit. An eligible insured who qualifies to receive this benefit may receive benefits for a hospitalization to a maximum of 120 days. Hospitalization related to childbirth requires a minimum of 1 day hospitalization.**

**HOSPITALIZATION DETAILS:**

| | | |
|---|---|---|
| **Name of Hospital:** | | |
| **Address:** | | |
| **City:** | **Province:** | **Postal Code:** |
| **Date of Admission:** Month/Day/Year | **Discharge Date:** Month/Day/Year | |
| **Please provide diagnosis and/or reason for hospitalization.** | | |
| | | |
| | | |

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

**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 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. This authorization shall be valid until withdrawn. I understand that I may revoke my consent and authorization at any time.

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

Member's Signature _____ Date _____

Signature of Claimant or Parent, if Claimant is a Minor _____ Date _____

Signature of Representative (POA), if applicable _____ Date _____

The furnishing of this form, or its acceptance by the Company, shall not be construed as the acceptance of the claim or admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

## SECTION B: TO BE COMPLETED BY THE ADMINISTRATOR

### POLICY HC10395007 – LABOURERS' UNION LOCAL 506 MEMBERS' BENEFIT TRUST FUND

| **FOR OFFICE USE ONLY<br>ADMINISTRATOR AUTHORIZATION** | |
|---|---|
| **Member's Name:** | **Member's I.D. No.:** |
| **Claimant's Name:** | **Relationship to Member:** |
| **Claimant's Effective Date:** Month/Day/Year | **Claimant's Termination Date, if any:** Month/Day/Year |
| **Amount of Cash Benefit: $ / day** | |
| **Administrator's Name (Please Print):** | |
| **Administrator's Title:** | |
| **Daytime Telephone No.: ( ) Ext.** | |
| **Instructions for the Claim:** | |
| | |

Administrator's Signature _____ Date _____