Attending Physician Statement

Underwritten by: AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200 ● Toronto, Ontario M5J 0A8
Phone: 1-800-461-8347 ● Fax: 855-558-0014

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

Please Print Clearly

Name of Patient:_____ **Age:**_____

Address of Patient:_____ **Province**_____ **Postal Code**_____

Name of Insured Organization:_____ **Policy Number**_____

Please Have Patient Sign

I authorize, for a period of not less than twelve and not more than twenty-four months 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 obtaining information from the group policyholder, an employer or an organization to which I provide services as an independent contractor) to release and exchange with AIG Insurance Company of Canada, 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. A photostatic copy of this authorization shall be considered as effective ad valid as the original.

Signature of Insured Member:_____ Date:_____

Dear Doctor, the above named individual has filed a claim for benefits under the above noted policy for which he/she is currently or has been under your care. In order that we might give this claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us. **PLEASE NOTE**: **The Company does not assume any expense incidental to the completion of this form.**

1) Diagnosis and Nature of Injury (If fracture, specify bone and type of fracture)

2 A) When did symptoms first appear or accident happen? Date: _____

B) When did Patient first consult you for this condition? Date:_____

C) Has Patient ever had same or similar condition? ☐ Yes, Please indicate Date:_____ ☐ No

3 A) Was this patient hospitalized for this injury? ☐ Yes, Please indicate Date:_____ ☐ No

B) If this patient was confined to the hospital, how many nights were they confined as an Inpatient? _____days

C) Name of Surgical Procedure, if Any _____Date Performed:_____

D) Name of Hospital:_____Address:_____

E) What other services, if any did you provide the Patient?

4. A) Is Patient still under your care for this condition? ☐ Yes ☐ No, If No, Please indicate date released:_____

B) How Long was or will patient be continuously Totally Disabled (Unable to Perform his/her Regular Occupation) due to diagnosis in #1 Section?

From _____ thru _____

Note: Do not Complete if Patient is Totally Disabled

C) How Long was or will patient be continuously Partially Disabled (Unable to Perform some but not all of his/her Regular Occupation)

From _____ thru _____

D) Approximate Date of Patient's Return to work: Date: _____

Please Print Attending Physician's Name_____ Degree_____ Date:_____

Signature of Attending Physician_____Phone #: (____)_____ Fax #: (____)_____

Address:_____Province_____Postal Code_____