Critical Illness Claim Report

Underwritten by: AIG Insurance Company of Canada
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PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE
2 Pages

1. Full name of Insured:_____

2. Date of Birth:_____Policy No._____ Cert #_____

In order for a claim for cancer to be paid under this Critical Illness insurance policy, the following definition must be satisfied.

The term " Life threatening cancer" means a disease of the Insured Member which is first manifested while the Insured Member's insurance under this contract and which is characterized by the presence of a malignant tumor and by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For the purposes of this definition, "Life Threatening Cancer" does NOT mean any of the following:

1. pre-malignant lesions, benign tumors or polyps;
2. leukoplakia;
3. hyperplasia;
4. carcinoid;
5. any tumors in the presence of any human immuno-deficiency virus (HIV);
6. polycythemia;
7. stage 1 Hodgkin's disease;
8. stage A prostate cancer;
9. Duke's stage A colon cancer;
10. intraductal non-invasive breast cancer;
11. stage 0 or 1 transitional cell carcinoma of urinary bladder; and
12. non-invasive cancer in situ or any skin cancer other than malignant melanoma invading into the dermis or deeper.

No Benefit is payable if diagnosis of any Life Threatening cancer is made within 90 days following the policy issue date.

Please print or type all your answers.

1. a) On what date did your patient first have symptoms? M _____ D _____ Y _____

   What were they? _____

   _____

   _____

   b) On what date did your patient first consult you for this condition? M _____ D _____ Y _____

   c) How long has this person been your patient? _____

2 a) Please give the date the cancer was diagnosed: M _____ D _____ Y _____

   b) On what date was the patient advised of the diagnosis: M _____ D _____ Y _____

   By Whom?_____

3. Please provided a copy of the pathology report giving the following details:
   a) Type of tumor:_____

   _____

   b) Site of tumor:_____

   _____

   c) Histology and taging:_____

   _____

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4. Please give the names and address of other physicians consulted or hospitals attended by your patient for his cancer: Name:_____ Address:_____

   Name:_____ Address:_____

   Name:_____ Address:_____

5 a) Has you're your patient previously suffered from cancer or predisposing disorders? ☐ Yes ☐ No

If so, please give dates and details: _____

_____

_____

b) Has your patient ever been tested for the Human Immunodeficiency Virus? ☐ Yes ☐ No

Date: M _____ D _____ Y _____ Results _____

6. a) Is there a Family history of Cancer ☐ Yes ☐ No

Please give details: _____

_____

_____

7. Please give details of patient's tobacco use including amount per day and date last used: _____

_____

_____

8. Please give below any other information that would be helpful in the assessment of your patient's claim.

_____

_____

_____

_____

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 nor does the Company assume any expense incidental to the completion of this form