

Critical Illness Claimant Statement Underwritten by: AIG Insurance Company of Canada

PLEASE COMPLETE
THIS FORM IN FULL
FOR PROMPT SERVICE

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

3. Dates Hospitalized(M/D/Y): From:	N	ame of Policyholder:	Policy No
C) Occupation:	1.	A) Full name of the Ins	sured:
2. Date of Birth(M/D/Y):		B) Residence:	
3. Dates Hospitalized(M/D/Y): From:		C) Occupation:	Employer's Name:
4. Advise nature of illness and when and where symptoms first occurred: Social Physician Social Physici	2.	Date of Birth(M/D/Y):	
B)Name and address of Consulting Physician(s): B)Name and address of Family Physician: C)Name and address of Family Physician: B)Name and address of Family Physician: B)Name and address of Family Physician: C)Name and address of Family Physician: C)Name and address of Family Physician: B)Name and address of Family Physician: C)Name and address of Family Physician: B)Name and address of Family Physician: C)Name and address of Family Physician: B)Name and address of Family Physician Physician and address of Family Physician Physici	3.	Dates Hospitalized(M/	D/Y): From: To:
B)Name and address of Family Physician: 6. Have you ever been treated for this or a related/similar Illness? Yes No B) If Yes, provide date(s) first consulted and name and address of treating Physician(s): 7. Please advise names of any prescription medications you are presently taking: 7. Please advise names of any prescription medications you are presently taking: PERSONAL INFORMATION NOTICE: 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, 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. CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims 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. 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. AUTHORIZATION: The 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, institution or association (including obtaining information from the group policyholder or my employery or rel	4.	Advise nature of illnes	s and when and where symptoms first occurred:
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Address:	res "Ins apprexistance of control	pect of my claim, is resurer") to assess my endicability of exclusions sting insurance files about exchange information RTIFICATION: The stamplete to the best of my rerage can be cancelled amount of any payment THORIZATION: I author physician, practitioned dical or medically relation or organization, beneonganization, institution di exchange with AIG I ment, employment or fluested while administerionical exchange with alministerionical exchan	equired by AIG Insurance Company of Canada its reinsurers and authorized administrators (the atitlement to benefits, including but not limited to determining if coverage is in effect, investigating the and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its out me, collect additional information about and from me, and where required, collect information from with, third parties. Itements I provide in completing this claim form and otherwise in respect of my claims are true and y knowledge and belief. In the event of a false or misleading statement in the making of this claim, d, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, at made in the event that such amounts should not have been paid in respect of my claim. For a period of not less than twelve and not more than twenty-four months from the date hereof, r, health care provider, hospital, health care institution, medical organization, clinic and any other additional diffusion administrator, federal, territorial or provincial government department, or any other corporation or association (including obtaining information from the group policyholder or my employer) to release insurance Company of Canada, or representatives thereof, all personal health information, benefit financial information about me or any other information or records about me in its possession that is ring my claim.
Address:Date:	Sig	nature:	Witness:
	Add	dress:	Date: