Critical Illness Claimant 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

Name of Policyholder: _____ Policy No._____

1. A) Full name of the Insured: _____

   B) Residence: _____

   C) Occupation:_____Employer's Name: _____

2. Date of Birth(M/D/Y): _____

3. Dates Hospitalized(M/D/Y): From:_____ To:_____

4. Advise nature of illness and when and where symptoms first occurred: _____

   _____

5. A) Name and address of Consulting Physician(s): _____

   _____

   _____

   _____

   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:

   _____

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: 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 or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial 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 the original.

Signature:_____Witness: _____

Address: _____ Date: _____

The furnishing of forms shall not be an admission of liability by the Company.