CCWU care

BUILDING HEALTHY FUTURES

CCWU™

Canadian Construction Workers Union Benefit Trust Fund

ACCIDENTAL DISMEMBERMENT (OCCUPATIONAL)

CANADIAN CONSTRUCTION WORKERS UNION BENEFIT TRUST FUND

ACCIDENTAL DISMEMBERMENT (OCCUPATIONAL)

SUBMISSION INSTRUCTIONS:

- Member to complete and sign the Claimant's Statement and Authorization Form (or Power of Attorney, if applicable).
- Attending Physician to complete and sign the Physician's Statement.
- Include any supporting documentation (ie. police records, medical records, etc). Please keep a copy of complete application package for you records to substantiate your claim.
- Policy No. AB10357402.
- Send completed application and supporting documents via fax, e-mail or mail to:

CCWUcare
200 Labourers Way, Suite 2100
Vaughan, ON L4H 5H9

Tel: 416-240-0047
Fax: 416-240-7488
Email: lifeeventclaims@bpagroup.com

CHUBB

PROOF OF LOSS
DISMEMBERMENT CLAIM
CLAIMANT'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

THIS SECTION TO BE COMPLETED BY THE CLAIMANT

Policy No.:		
Claimant's Name:		**Phone #: ( )**
Full Mailing Address:		
City:	**Province:**	**Postal Code:**
Sex: ☐ **Male** ☐ **Female**	**Date of Birth:**	
Name of Current Employer:	**Occupation:**	
Employer's Address:		
Date and Time when Accident Occurred:		**Time:** ☐ **AM** ☐ **PM**
Where did the accident happen?		
How did the accident occur? (describe fully)		
What injuries were incurred as a result of this accident?		
Name and Addresses of all Doctors consulted (Attach a separate list if necessary)		
1.		
1st treatment Date:		
2.		
1st treatment Date:		
3.		
1st treatment Date:		
Were you hospitalized as a result of this accident? ☐ **Yes** ☐ **No If yes, Name and Address of Hospital:**		
From:		**Time:** ☐ **AM** ☐ **PM**
To:		**Time:** ☐ **AM** ☐ **PM**
Are you receiving any other insurance benefits as a result of this accident? ☐ **W.C.B./W.S.I.B.** ☐ **C.P.P./Q.P.P.** ☐ **Employer Disability** ☐ **Automobile Ins.** ☐ **Other:**		
Company:	**Benefit Type:**	**Amount:**

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, 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, 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.

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

Claimant's Signature_____ Date _____

CHUBB

AUTHORIZATION TO OBTAIN INFORMATION (CLAIMANT)

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

Name of Insured:

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning myself to give to Chubb Insurance or Chubb Life Insurance all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as a claimant and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this consent shall be as valid as the original.

Name (Please Print) _____ Signature _____

Dated at _____ of _____
City/Town Region/Municipality

In the Province of _____ on this _____day

of _____.
Month and Year

Signature of Patent/Guardian if Child is a Minor _____

CHUBB

PROOF OF LOSS / DISMEMBERMENT CLAIM
ATTENDING PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

First Name of Patient:	Last Name of Patient:	Date of Birth:

HISTORY

a) When did symptoms first appear or accident happen?	
b) Date patient ceased work because of disability:	
c) Has patient ever had same or similar condition: ☐ Yes (state when & describe) ☐ No ☐ Unknown	
d) Is condition due to injury or sickness arising out of employment? ☐ Yes ☐ No	
e) Names of any other treating Physicians:	**Address:**
Names of any other treating Physicians:	**Address:**

DIAGNOSIS, NATURE OF LOSS

a) Primary (if fracture or dislocation, state whether complete or incomplete)
b) Secondary (if applicable)
c) Did any disease or previous injury contribute to the loss? Please provide details:
d) Is loss permanent and irrecoverable? Please provide details:

TREATMENT

a) Date of First Visit:	
b) Date of Latest Visit:	
c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify):	
d) Date of Hospitalization: Confined From:	**To:**
Hospital Name:	
e) Nature of Treatment (including medication, therapy and surgery, if any)	

PHYSICAL IMPAIRMENT

Degree of Limitation of Functional Capacity:
☐ Class 1 – No Limitation: Capable of heavy work. No Limitations. (0-10%)
☐ Class 2 – Significant Limitation: Capable of light manual activity. (15-30%)
☐ Class 3 – Moderate Limitation: Capable of Clerical/Administrator (sedentary) activity. (35-55%)
☐ Class 4 – Marked Limitation. (60-70%)
☐ Class 5 – Severe Limitation: Incapable of minimal (sedentary) activity. (75-100%)
Remarks:

VISUAL (IF APPLICABLE)

(For loss of vision due to accident only)			
What was vision at latest observation?	**With glasses:**	**O.D.**	**O.S.**
	Without glasses:	**O.D.**	**O.S.**
Vision can be restored in whole or part by:	**O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable**		
	O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable		

REMARKS

Name of Attending Physician:	**Degree:**	
Phone #: ( )	**Fax #: ( )**	
Address:		
City:	**Province:**	**Postal Code:**

Signature_____ Date _____

PLEASE NOTE THAT ALL CHARGES FOR THE COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE CLAIMANT