CCWU care

BUILDING HEALTHY FUTURES

CCWU™

Canadian Construction Workers Union Benefit Trust Fund

CRITICAL ILLNESS

Meningitis, Brain Tumor, Coma, Stroke

CANADIAN CONSTRUCTION WORKERS UNION BENEFIT TRUST FUND

CRITICAL ILLNESS

SUBMISSION INSTRUCTIONS:

- Complete Claimant's Statement *(Individual diagnosed with the Critical Illness)* (Completed and signed by Member/Spouse or Power of Attorney).
- Physician's Statement to be completed and signed by your Physician.
- Include any supporting medical records. Please keep a copy of complete application package for you records to substantiate your claim.
- Policy No. CI 9143303B.
- Send all completed applications to:

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

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

AIG c/o CCWUcare
200 Labourers Way, Suite 2100
Vaughan, ON L4H 5H9

CLAIMANT STATEMENT
Critical Illness

Name of Policyholder: **Policy No.:**

1. a) Full name of claimant:
   b) Address:
   c) Date of birth (*MM/DD/YY*):
   d) Full name of member (*if different*):
   e) Relationship to member: ☐ Spouse ☐ Common-Law ☐ Dependent Child
   f) Capacity in which claim is being made (*if applicable*): ☐ Beneficiary ☐ Executor ☐ Assignee ☐ Other (*explain*):
2. a) Nature of illness:
   b) Date of onset of symptoms (*MM/DD/YY*):
   c) Date of initial medical attention (*MM/DD/YY*):
   d) Have you ever been treated for this or related/similar illness or condition? ☐ No ☐ Yes (*provide*):

Name of Treating Physician(s)	*Address of Treating Physician(s)*	*Date (MM/DD/YY)*

   e) Were you hospitalized? ☐ No ☐ Yes (*provide*):

Name of Hospital(s)	*Address of Hospital(s)*	*Date From:*	*Date To:*

3. Name and address of consulting and family physicians:

	Name	*Address*
Consulting Physician(s):		
Family Physician:		

4. Names of any prescribed medications you are presently taking:

PERSONAL INFORMATION NOTICE AND CONSENT: 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, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside Canada for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.
CERTIFICATION: I declare that to the best of my knowledge and belief, the above particulars and the statements I provide in completing this claim form and otherwise in respect of my claims are true and accurate. I understand that any misrepresentation or omission of any material fact may result in denial of the claim, coverage may be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer the full amount of any payments made to me with respect to any claims of me or my dependents if it is determined that such amounts should not have been paid in respect of such claims, and agree that the Insurer may set off any such amount against any other benefits payable to me with respect to any claims of me or my dependents by the Insurer until the Insurer has recovered such amount in full.
AUTHORIZATION: I authorize, for a period of two (2) years 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 the group policyholder) to release and exchange with, and my employer to release and disclose to, the Insurer, 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. I agree that a reproduction of this authorization shall be as valid as if it were the original.

Signature: Date (*MM/DD/YY*): Phone number:

Address:

Email: Witness:

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

AIG c/o CCWUcare
200 Labourers Way, Suite 2100
Vaughan, ON L4H 5H9

PHYSICIAN STATEMENT
Critical Illness – Bacterial Meningitis, Benign Brain Tumor, Coma, Stroke (CVA)

In this Physician statement, "you" and "your" mean the Physician who completes it; "we", "us" and "our" mean AIG Insurance Company of Canada, the insurer providing **Critical Illness** *coverage.*

THE CLAIMANT IS RESPONSIBLE FOR ANY CHARGE INCURRED FOR COMPLETION OF THIS FORM.

1. a) Full name of patient:
   b) Date of birth (*MM/DD/YY*):

2. a) Patient's condition: ☐ Bacterial Meningitis ☐ Benign Brain Tumour
   ☐ Coma ☐ Stroke (Cerebrovascular Accident)
   b) Date of onset of clinical manifestations (*MM/DD/YY*):
   c) Date of initial medical attention (*MM/DD/YY*):
   d) Full final diagnosis, including complications:
   e) Date of final diagnosis (*MM/DD/YY*):
   f) Name of physician who made diagnosis: Specialty:
   g) Names and addresses of physicians consulted and/or hospitals attended by patient for this condition:

Name of Physician/Hospital	*Address of Physician/Hospital*	*Date From:*	*Date To:*

   h) How long has this person been your patient?

3. **Please complete a section below pertinent to your patient's condition:**

Bacterial Meningitis

a) Was diagnosis confirmed by: ☐ Cerebrospinal fluid culture test ☐ Blood culture test
Please enclose test result(s) confirming diagnosis

b) Has patient's condition resulted in neurological deficits persisting for 90 days or more?
☐ No ☐ Yes (*specify neurological deficit(s) that persisted for 90 days or more*):
☐ Measurable loss of hearing ☐ Objective loss of sensation ☐ Paralysis
☐ Localized weakness ☐ Dysarthria ☐ Dysphasia
☐ Dysphagia ☐ Measurable visual impairment ☐ Impaired gait
☐ Difficulty with balance ☐ Lack of coordination ☐ Seizure undergoing treatment
☐ Measurable changes in neuro-cognitive function
☐ Other (*specify*):

c) Please enclose copies of medical records supporting diagnosis (diagnostic test results, CT scan and/or MRI reports, consultation/progress notes indicating progression of illness, discharge summary, etc.)

Benign Brain Tumor

a) Has patient undergone surgical treatment? ☐ No ☐ Yes (*specify*):

Procedure name (*enclose surgery/operative report*):

Procedure date (*MM/DD/YY*):

b) Has patient undergone radiation treatment?

☐ No ☐ Yes (*list medication(s) prescribed and prescription date*):

c) Has patient's condition caused irreversible objective neurological deficit(s)?

☐ No ☐ Yes (*specify deficits*):

☐ Measurable loss of hearing ☐ Objective loss of sensation ☐ Paralysis

☐ Localized weakness ☐ Dysarthria ☐ Dysphasia ☐ Dysphagia

☐ Measurable visual impairment ☐ Impaired gait ☐ Difficulty with balance

☐ Lack of coordination ☐ Seizure undergoing treatment

☐ Measurable changes in neuro-cognitive function

☐ Other (*specify*):

d) Please enclose copies of medical records supporting diagnosis and treatment (histopathology and CT scan/MRI reports, consultation/progress notes, operative/surgery report, discharge summary, etc.)

Coma

a) Was patient diagnosed with coma? ☐ No ☐ Yes (*indicate*):

Date of diagnosis (*MM/DD/YY*):

Type of coma: ☐ Medically induced ☐ Persistent vegetative state ☐ Toxic-metabolic encephalopathy

b) Was patient's comatose condition a direct result of?

☐ Trauma (*head injury*) ☐ Stroke ☐ Alcohol use ☐ Drug use ☐ Infection

☐ Other (*specify*):

c) Has patient's comatose condition lasted for a continuous period of 96 hours or more?

☐ No ☐ Yes (*indicate patient's Glasgow Coma Scale Score during period of unconsciousness*):

Term of Unconsciousness	*Date From:*	*Date To:*	*Glasgow Coma Scale Score*
☐ 1st 24 hours			
☐ 2nd 24 hours			
☐ 3rd 24 hours			
☐ 4th 24 hours			

d) Was patient diagnosed with brain death? ☐ No ☐ Yes (*indicate*):

Date patient diagnosed with brain death (*MM/DD/YY*):

e) Please enclose copies of medical records supporting diagnosis (CT scan, MRI test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

Stroke (Cerebrovascular Accident)

a) Date of onset of new neurological symptoms (*MM/DD/YY*):

b) Patient's symptoms:

c) Was patient diagnosed with stroke? ☐ No ☐ Yes (*specify*):

Type of stroke: ☐ Ischemic ☐ Haemorrhagic ☐ Transient ischemic attack (TIA)

☐ Intracerebral vascular event ☐ Ischemic disorder of vestibular system

☐ Lacunar infarct ☐ Other (*specify*):

d) Has patient's condition resulted in objective residual neurological deficits persisting for more than 30 days?

☐ No ☐ Yes (*specify neurological deficit(s) that persisted for more than 30 days*):

☐ Measurable loss of hearing ☐ Objective loss of sensation ☐ Paralysis

☐ Localized weakness ☐ Dysarthria ☐ Dysphasia ☐ Dysphagia

☐ Measurable visual impairment ☐ Impaired gait ☐ Difficulty with balance

☐ Lack of coordination ☐ Seizure undergoing treatment

☐ Measurable changes in neuro-cognitive function

☐ Other (*specify*):

e) Please enclose copies of medical records supporting diagnosis (CT scan, MRI test results, consultation/ progress notes indicating progression of illness, discharge summary, etc.)

4. Please provide any other information that would be helpful in assessment of this claim:

These statements are true and complete to the best of my knowledge and belief.

By signing below, you confirm that you understand and agree that the information you provide on this form becomes part of the patient's Critical Illness file and that we may share that information with affiliates of AIG Insurance Company of Canada, the beneficiary or beneficiaries, applicable reinsurers, authorized third parties, including without limitation, third party service providers, and, where authorized by law, government entities, including financial services regulatory bodies and with other insurance companies to allow them to administer insurance with respect to the patient. Disclosures of information on this form will occur in accordance with AIG Canada's Privacy Principles available at www.aig.ca

Name of Attending Physician:

Address:

Signature of Attending Physician: Date (*MM/DD/YY*):

Phone number: Fax number:

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