Member Companies of American International Group, Inc.

American Home Assurance Company
Accident & Health Claims Department
145 Wellington St. West
Toronto, Ontario M5J 1H8
Phone (416) 596-4005
Fax: (416) 596-4067

CLAIMANT'S STATEMENT - PLEASE PRINT

Policy Number: ______________________

Claimant's Surname: ______________________ Claimant's Given Name: ______________________

Address (Street & No.) ______________________

Apt./Unit No. ______________________ Telephone No.: ______________________

City/Town ______________________ Province ______________________ Postal Code ______________________

Date of Birth: D / M / Y Sex: ☐ Male ☐Female

1. Date of Accident: ______________________ Date of Initial Medical attention: ______________________

2. Full Details of Accident: ______________________

3. What injuries were sustained: ______________________

4. Name and Address of Family Physician: ______________________

5. Name and address of witness to this accident: ______________________

6. Name and Address of Surgeons or Specialists who provided treatment regarding this accident: ______________________

7. Please provide term of totally disability which prevented you from engaging in your pre-accident occupation (please attach supporting medical certification) From: ______________________ To: ______________________

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 American Home Assurance Company, 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 fil about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. **CERTIFICATION**: Th 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, th 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 American Home Assurance Company, 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 of Insured or Insured's Parent/Guardian (if under age 18) Date

**** PLEASE HAVE YOUR PHYSICIAN COMPLETE THE REVERSE SIDE OF THIS FORM. ****

PHYSICIAN'S STATEMENT - PLEASE PRINT

Name of Patient:

Full description of injury sustained:	DATE	First Attendance: D / M / Y
	OF	Actual Loss: D / M / Y

Is loss permanent and irrecoverable? Give degree of loss

Did any disease or previous injury contribute to loss? ( ) No, and if ( ) Yes - Describe

Was claimant hospitalized? ( ) No, and if ( ) Yes - Give hospital name, address and date admitted.

Names and addresses of other physicians or surgeons, if any, who attended claimant.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: ______________ SIGNATURE: ______________ (M.D.)

ADDRESS: ______________