AIG

Member Companies of American International Group, Inc.

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

PLEASE PRINT

POLICY NO.:

CLAIMANT'S STATEMENT

Surname: Given Name

Address: (Street & No.)

Apt./Unit No.: Telephone No.: ( )

City/Town Province Postal Code:

Date of Birth: Sex: Male Female

1. Date of Accident:

2. Full details of accident and injury sustained:

3. Have you had a similar injury previously? Yes No

Provide dates and details:

4. Name and Address of Physician:

5. Where and when did your Physician first attend you?

6. Names and Addresses of any other physicians who may have treated you as the result of this accident.

7. What other accident or health insurance do you have?

Company: Indemnity:

8. Are you receiving a disability pension, W.S.I.B. or unemployment benefits? Yes ( ) No ( )

If "yes", for what? Amount: $ Date of First Payment:

9. (a) Are you/were you totally disabled? Yes ( ) No ( ) From To

(b) Are you/were you house confined? Yes ( ) No ( ) From To

(c) Are you/were you hospitalized? Yes ( ) No ( ) From To

f "yes", name and address of Hospital

10. (a) When did you or will you resume work - PART TIME? Date: Time: AM/PM

(b) When did you or will you resume work - FULL TIME? Date: Time: AM/PM

I hereby certify that the above answers are both true and complete:

Date: Claimant sign here:

AUTHORIZATION TO RELEASE

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 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 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.

Dated: Claimant sign here:

ATTENDING PHYSICIAN'S STATEMENT

Physician's Name (Print)

Name: _____

Street: _____

City: _____

Prov. _____ Postal Code: _____

Patient's Name (Print)

Name: _____

Street: _____

City: _____

Prov. _____ Postal Code: _____

Diagnosis including complications (if fracture, specify bone and type of fracture) and Nature of Injury:

_____

_____

_____

DATE OF

First Attendance D M Y

Actual Loss

Please outline the treatment plan recommended and prescribed: _____

_____

_____

Date of next scheduled follow up appointment: _____

Is your patient totally disabled and unable to perform their occupational responsibilities? ☐ Yes ☐ No

Please provide the term of total disability: From: _____ To: _____

Please provide the expected return to work date: _____

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: _____

EMPLOYER'S STATEMENT

Name of Employee: _____ Date of Employment: _____

Name of Employer: _____

Address of Employer: _____

_____

Did the injury occur while claimant was performing the regular and assigned duties of their occupation? Yes ☐ No ☐

Did the injury occur while claimant was travelling directly to or from their regular place of employment? Yes ☐ No ☐

Description of Injury: _____

Employee was: ☐ Hourly ☐ Salary ☐ Commissioned ☐ Other(explain) _____

Weekly Salary: _____ Occupation/Job Title: _____

Date Last Worked: _____

Will or is this employee receiving any source of income replacement during his/her term of disability (i.e. W.S.I.B, short/long term disability benefits). If yes; please advise source and amount being paid:

_____

Date : _____ Signature: _____

Telephone No.: _____ Title: _____