Initial Claim Report

Underwritten by: AIG Insurance Company of Canada
145 Wellington Street West • Toronto, Ontario M5J 1H8
Phone: 1-800-461-8347 • Fax: 416-596-4067

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

TO BE COMPLETED BY INJURED PERSON

Name:_____ Social Insurance Number_____

Home Address:_____City:_____Province_____Postal Code_____

Telephone Number: Home: (____)_____ Work: (____)_____ Email:_____

Date of Birth:_____ Sex: ☐ M or ☐ F Height:_____ Weight:_____ Marital Status:_____ Gross Weekly Wage: $_____/wk

Employer Name_____ Full-time Occupation:_____ # of Yrs Worked at this job_____

Employer Address:_____City:_____Province_____Postal Code_____

Please answer the next 3 questions in detail:

1) Exactly what activity of your organization were you involved in when injured or became ill?

2) How did the accident or illness occur?

3) Exactly what is your injury or illness?_____

Date of Accident:_____20_____ Occurred:_____ ☐AM ☐PM

Give date of first day of full-time occupation missed due to above accident & illness:_____ 20_____

How many days hospitalized overnight?_____ Give date you are/were able to return to work_____20_____

Attending Physician: Dr._____(____)_____
Name Address Telephone #

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, an employer or an organization to which I provide services as an independent contractor) to release and exchange with AIG Insurance Company of Canada, 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 the original.**

Dated:_____ Signature:_____

TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

Policy Number_____ What type of Policy? ☐ Firefighter ☐ Councilor ☐ Non-Profit Volunteer ☐ Other

Select which category the Injured person is insured as? ☐ Member (Firefighter or Councilor) ☐ Non-member ☐ Spouse ☐ Dependent

What activity was the injured person engaged in at the time of injury or sickness? ☐ On Duty (Authorized) ☐ Off Duty (Not-Authorized)

Insured Organization Name:_____Address_____

Daytime phone #(____)_____ Fax # (____)_____ Email address:_____

Print name of Signing Official_____ Title_____

I hereby certify the above is true (Signature)_____ Date:_____

Attending Physician Statement

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PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

Please Print Clearly

Name of Patient:_____ **Age:**_____

Address of Patient:_____ **Province**_____ **Postal Code**_____

Name of Insured Organization:_____ **Policy Number**_____

Please Have Patient Sign

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, an employer or an organization to which I provide services as an independent contractor) to release and exchange with AIG Insurance Company of Canada, 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. A photostatic copy of this authorization shall be considered as effective ad valid as the original.

Signature of Insured Member:_____ Date:_____

Dear Doctor, the above named individual has filed a claim for benefits under the above noted policy for which he/she is currently or has been under your care. In order that we might give this claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us. **PLEASE NOTE: The Company does not assume any expense incidental to the completion of this form.**

1) Diagnosis and Nature of Injury (If fracture, specify bone and type of fracture)

2 A) When did symptoms first appear or accident happen? Date:_____

B) When did Patient first consult you for this condition? Date:_____

C) Has Patient ever had same or similar condition? ☐ Yes, Please indicate Date:_____ ☐ No

3 A) Was this patient hospitalized for this injury? ☐ Yes, Please indicate Date:_____ ☐ No

B) If this patient was confined to the hospital, how many nights were they confined as an Inpatient? _____days

C) Name of Surgical Procedure, if Any _____Date Performed:_____

D) Name of Hospital:_____Address:_____

E) What other services, if any did you provide the Patient?

4. A) Is Patient still under your care for this condition? ☐ Yes ☐ No, If No, Please indicate date released:_____

B) How Long was or will patient be continuously Totally Disabled (Unable to Perform his/her Regular Occupation) due to diagnosis in #1 Section?

From _____ thru _____

Note: Do not Complete if Patient is Totally Disabled

C) How Long was or will patient be continuously Partially Disabled (Unable to Perform some but not all of his/her Regular Occupation)

From _____ thru _____

D) Approximate Date of Patient's Return to work: Date: _____

Please Print Attending Physician's Name_____ Degree_____ Date:_____

Signature of Attending Physician_____Phone #: (___)_____ Fax #: (___)_____

Address:_____Province_____Postal Code_____