



Initial Claim Report

Underwritten by: AIG Commercial 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 _____

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 #
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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 Commercial 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 Commercial 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)

Was injured person a member of your organization at the time of the above described incident? Yes No

Policy Number _____ What type of Policy?: Firefighter Councilor Non-Profit Volunteer Other

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
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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 Commercial 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: _____ 20____

B) When did Patient first consult you for this condition? Date: _____ 20____

C) Has Patient ever had same or similar condition? Yes, Please indicate Date: _____ 20____ NO

3 A) Was this patient hospitalized for this injury? Yes, Please indicate Date: _____ 20____ 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: _____ 20____

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: _____ 20____

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 _____ 20____ thru _____ 20____

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 _____ 20____ thru _____ 20____

D) Approximate Date of Patient's Return to work: Date: _____ 20____

Please Print Attending Physician's Name _____ Degree _____ Date: _____

Signature of Attending Physician _____ Phone #: (____) _____ Fax #: (____) _____

Address: _____ Province _____ Postal Code _____