AIG Insurance Company of Canada
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Toronto, ON M5J 0A8
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CLAIMANT STATEMENT
Accidental Dismemberment / Loss of Use

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

1. a) Full name of claimant:
   b) Address:
   c) Date of birth (MM/DD/YY): d) Employer's name:
2. a) Date of accident (MM/DD/YY): b) Place of accident:
   c) Circumstances:
   d) Date of first medical attention (MM/DD/YY):
3. a) What injuries were sustained?
   b) Type of Claim: ☐ Paralysis ☐ Loss of Use of (explain):
   ☐ Dismemberment of (explain):
   ☐ Loss of Sight ☐ Loss of Hearing ☐ Loss of Speech
4. a) Name and address of family physician:
5. a) Hospitalization dates (MM/DD/YY): From: To:
   b) Name of hospital:
6. a) Name and address of **physicians** who provided treatment regarding this accident:

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.

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