How to Claim

In the event you need to report a claim, please call:

Local - 416- 596-4005
Toll Free - 1-877-317-8060

The Accident and Health Claims Dept. is available from 8:00 am to 5:00 pm (Eastern Standard Time) Monday to Friday with service available in both English and French. Voicemail messages are returned within 1 business day.

Notice and Proof of Claim

The Policyholder, the Insured Person, the beneficiary or an agent/broker on behalf of the Policyholder, Insured Person or beneficiary is entitled to make a claim. Written notice of the claim should be sent to the Company by regular or registered mail, to the Head Office of the Company.

(a) Notice of a Claim should be given not later than thirty (30) days from the date of the accident.

(b) Proof of Claim (your claim forms and any supporting documents) should be filed within ninety (90) days from the date of the accident or the Injury or as soon as is reasonably possible in the circumstances of the happening of the accident or Injury.

(c) And, if so required by the Company, furnish a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from a legally qualified medical practitioner.

Failure To Give Notice Or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one (1) year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Accidental Death & Dismemberment

Should an Insured Person sustain bodily injury or loss of life as the result of an accident occurring while he or she was engaged in a Covered Activity, an Accidental Death or Dismemberment claim form will need to be completed.

When you call to report an Accident or an Accidental Death, a claims examiner will complete an AD&D Initial Report Form, which includes the following questions;

- Name of deceased or injured party
- Policy Number: SRG 9124624
- AD&D Benefit Amount
- *Name and address of next of kin and their relationship to the deceased
- Insured's date of birth
- Date of accident and details of event
- Address where claim forms are to be sent

(*In the case of death claims only)

Cont'd.../2

How to Claim—Continued-2

With this information we can start to set up a claim file to expedite the claim's process, so that when the claim forms are received a file has already been set up. This information will also assist us in determining the appropriate claim forms that will need to be sent.

For your convenience, we can arrange to send claim forms by mail, fax or email.

In the case of an **Accidental Death claim,** documents would include;

- Claimant's Statement to be completed by the Named Beneficiary
- Administrator's Statement to be completed by the Policyholder
- Attending Physician's Statement or Coroner's Report
- Police report (if applicable) example: Motor vehicle accidents
- Death Certificate
- Proof as registered member

In the case of an **Accidental Dismemberment, Paralysis or Loss of Use claim,** documents would include:

- Claimant's Statement to be completed by injured party
- Attending Physician's Statement
- Administrator's Statement
- Proof as registered member

Please note that we require that the original claim documents be submitted to our office for review. We do not accept faxed or photocopied claim forms.

Upon receipt of the documents in our office, the assigned claims examiner will start their review of the claim and advise the insured/beneficiary accordingly. Please note that all correspondence will be sent directly to the insured or beneficiary.

Accidental Paramedical Expense Reimbursement*, or
(covers expenses incurred in Canada that are not covered under Federal/Provincial Health Plans)

Dental Expense Reimbursement*

Should an Insured Person incur medical or dental expenses resulting from an accident occurring while participating in a Covered Activity, please have them complete the required claim form in full, attach the medical/dental receipts/invoices to the claim and forward both the original claim forms and invoices to our office for review.

**please refer to your policy contract for maximum benefit amounts that may apply.*

Other Useful Contract information

If you have any questions regarding your insurance policy, please feel free to contact AIG Insurance Company of Canada at the following:

Claims Questions:
General Inquiries (416) 596-4005 (toll free 1-877-317-8060) or e-mail ahclaimscan@aig.com

AIG Insurance Company Of Canada
145 Wellington Street West
Toronto, ON M5J 1H8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

POLICY NO.: _____

ACCIDENT CLAIM FORM
Claimant's Statement

Please print and please ensure that original claim documents and invoices are submitted

Surname: Given Name

Address:
(Street & No.)

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

City/Town Province Postal Code:

Date of Birth (M/D/Y): Height: Weight: Sex: ☐ Male ☐ Female

1. Date of Accident(M/D/Y):_____
2. Location of Accident:_____
3. Full details of accident and injury sustained:_____
4. Did the accident occur at a sanctioned event sponsored by the Policyholder? ☐ Yes ☐ No
   Explain: _____
5. Have you had a similar injury previously? Yes_____No_____
   Provide dates and details:_____
6. Name and Address of Physician:_____
7. Where and when did your Physician first attend you?_____
8. Names and Addresses of any other physicians who may have treated you as the result of this accident.
9. What other accident or health insurance do you have?
   Company:_____Indemnity:_____

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

Signature of Insured or Insured Person's Parent/Guardian (if under 18):_____Date:_____

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 or my employer) 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.

Signature of Insured or Insured Person's Parent/Guardian (if under 18):_____Date:_____

AIG Insurance Company Of Canada
145 Wellington Street West
Toronto, ON M5J 1H8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

ATTENDING PHYSICIAN'S STATEMENT

The patient is financially responsible for the completion of the form

Physician's Name (Print)

Name:_____

Address:_____

_____

Phone # _____

Patient's Name (Print)

Name: _____

Address:_____

_____

Phone # _____

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

_____

_____

_____

DATE OF

	M	D	Y
First Attendance			
Actual Loss			

Is condition due to an accident? Yes ( ) No ( )

Please outline the treatment plan recommended and prescribed:_____

_____

_____

Date of next scheduled follow up appointment:_____

Was claimant hospitalized? ( ) No ( ) 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: _____

ASSOCIATION'S STATEMENT

Name of Insured:_____**Insured's effective date:**_____

Insured's Classification (example: athlete, coach, participant, leader, guest, etc) _____

Did the injury occur while claimant was participating in a sanctioned event? NO ☐ YES ☐ Please describe:_____

_____

Description of Injury: _____

Please attach a copy of the completed Incident Report related to this event (if available).

Date :_____**Signature:**_____

Telephone No.:_____**Title:**_____