Cancer Benefit Claim Report

Underwritten by: AIG Insurance Company of Canada
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PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE
2 Pages

1. Full name of Insured:_____

2. Date of Birth:_____Policy No._____ Cert #_____

In order for a claim for cancer to be paid under this Critical Illness insurance policy, the following definition must be satisfied.

We will pay the Cancer Benefit Principal Sum shown in the **Schedule** to an **Insured Person** who is first diagnosed with "Life-Threatening Cancer**"** within the term of coverage and requires medical treatment, if such treatment is received within one year from the onset of diagnosis and the **Insured Person** survives at least 30 days after such diagnosis. The **Insured Person** must be eligible or approved for Provincial Workers Compensation benefits.

"Life-Threatening Cancer" – means a disease of the **Insured Person** which first manifested while the **Insured Person's** insurance under this contract is in effect and is a result of occupational hazards of a firefighter. "Life-Threatening Cancer" must be characterized by the presence of a malignant tumor and by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Life-Threatening Cancer" pertaining to this benefit includes, but is not limited to; Leukemia, Non-Hodgkin's Lymphoma, Kidney Cancer, Brain Cancer, Bladder Cancer or cancers identified under the Provincial Cancer Presumption Statute, for which treatment has been recommended.

Diagnostic Requirements – "Life-Threatening Cancer**"** must be positively diagnosed by a **Physician** and supported with pathological report. Clinical diagnosis alone does not meet this standard.

No Benefit is payable if diagnosis of any Life Threatening cancer is made within 90 days following the policy issue date.

Please print or type all your answers.

1. a) On what date did your patient first have symptoms? M _____ D _____ Y _____

   b) Does the patient have one of the Life Threatening Cancers listed above? Yes or No

   If so, which one of the Cancers listed above does your patient have?_____

   c) On what date did your patient first consult you for this condition? M _____ D _____ Y _____

   d) How long has this person been your patient? _____

2 a) Please give the date the cancer was diagnosed: M _____ D _____ Y _____

   b) On what date was the patient advised of the diagnosis: M _____ D _____ Y _____

   By Whom?_____

   c) Was Provincial Workers Compensation filed? Yes or No

   d) If yes, was the claim accepted under the Province's Presumptive Legislation ? Yes or No

3. Please provided a copy of the pathology report giving the following details:
   a) Type of tumor:_____
   _____
   b) Site of tumor:_____
   _____
   c) Histology and taging:_____
   _____

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4. Please give the names and address of other physicians consulted or hospitals attended by your patient for his cancer: Name:_____ Address:_____

   Name:_____ Address:_____

   Name:_____ Address:_____

5 a) Has you're your patient previously suffered from cancer or predisposing disorders? ☐ Yes ☐ No

If so, please give dates and details: _____

_____

_____

b) Has your patient ever been tested for the Human Immunodeficiency Virus? ☐ Yes ☐ No

Date: M _____ D _____ Y _____ Results _____

6. a) Is there a Family history of Cancer ☐ Yes ☐ No

Please give details: _____

_____

_____

7. Please give details of patient's tobacco use including amount per day and date last used: _____

_____

_____

_____

8. How Long was or will patient be continuously Totally Disabled (Unable to Perform his/her Regular Occupation) due to the Life Threatening Cancer? from M_____ D ____ Y ____ thru M_____ D ____ Y ____

Are you related to or in a business relationship with this patient? ☐ Yes ☐ No

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician:_____

Address:_____

Signature of Attending Physician_____Date:_____

The furnishing of forms shall not be an admission of liability by the Company nor does the Company assume any expense incidental to the completion of this form