



# GROUP CRITICAL ILLNESS CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact the Group Claims Department at 1-844-436-1105, 8:00 A.M. to 8:00 P.M. Eastern Standard Time, or at <http://mybenefits.allstatevoluntary.ca/>.

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

- To avoid delays in processing, please fill out the sections which apply to your specific claim.
- Include your certificate number. To obtain your certificate number, you may call 1-844-436-1105.
- You may fax your claim to us at 1-844-436-1107 or scan and electronically submit your claim at <http://mybenefits.allstatevoluntary.ca/>.
- You may also mail your claim to:
  - Group Claims**
  - Allstate Benefits**
  - PO Box 8100 Stn T**
  - Ottawa, ON K1G 3H6**
- Additional claim forms are available on our website at <https://mybenefits.allstatevoluntary.ca/>.

## INSURED AND PATIENT INFORMATION

1. Insured's Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Surname: \_\_\_\_\_

E-mail: \_\_\_\_\_ Certificate Number: (Use your 891 Union ID) \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

2. Daytime Phone Number: \_\_\_\_\_ Evening/Cell Phone Number: \_\_\_\_\_

3. Employer's Name: IATSE 891 Employee Life & Health Trust Occupation: \_\_\_\_\_

## PATIENT'S INFORMATION

4. Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Surname: \_\_\_\_\_

5. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

### INSTRUCTIONS FOR FILING CRITICAL ILLNESS CLAIMS:

- The results of a tissue specimen, culture(s) and/or titer(s) or other diagnostic studies, which initially diagnosed the critical illness, must accompany your claim. Include a copy of your Attending Physician's Statement.
- For waiver of premium, please have your attending physician fill out the section on page 3 of 3.

*Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing.*

**PLEASE CHECK THE BOX(S) THAT BEST DESCRIBES YOUR CLAIM**

Following are the benefits available under your Group Critical Illness Policy. Please check the benefit(s) you believe may be due based upon your condition. You will need to attach medical record documentation of your condition.

**CRITICAL ILLNESS BENEFIT** (Please check the illness for which you are requesting benefits.)

Alzheimer's Disease	<input type="checkbox"/>	*Medical record documentation by psychiatrist or neurologist
Benign Brain Tumour	<input type="checkbox"/>	*Pathology report
Carcinoma In Situ	<input type="checkbox"/>	*Pathology report
Invasive Cancer	<input type="checkbox"/>	*Pathology report
Coma	<input type="checkbox"/>	*Medical documentation showing state of unconsciousness for 14 or more consecutive days
Deafness	<input type="checkbox"/>	*Medical documentation showing diagnosis of total hearing loss in both ears
Blindness	<input type="checkbox"/>	*Medical documentation by ophthalmologist showing permanent loss of sight to 20 degrees or less in both eyes or corrected visual acuity or 20/200
Coronary Artery By-Pass Surgery	<input type="checkbox"/>	*Medical record or billing proof of procedure
Kidney Failure	<input type="checkbox"/>	*Medical record documentation showing proof of failure to both kidneys and proof of dialysis or transplant
Heart Attack	<input type="checkbox"/>	*Electrocardiograph proof and lab reports showing elevated cardiac biochemical markers
Paralysis	<input type="checkbox"/>	*Medical documentation showing diagnosis of the loss of muscle function of 2 or more limbs without severance
Parkinson's Disease	<input type="checkbox"/>	*Medical documentation by a neurologist showing inability to perform 2 or more daily living activities
Stroke	<input type="checkbox"/>	*Medical record documentation of permanent neurological deficit
Major Organ Failure (Transplant or Waiting List)	<input type="checkbox"/>	*Billing proof of procedure or proof of being enrolled in transplant centre
Multiple Sclerosis	<input type="checkbox"/>	*Medical record documentation showing diagnosis of multiple sclerosis
Aortic Surgery	<input type="checkbox"/>	*Medical record or billing proof of procedure
Severe Burns	<input type="checkbox"/>	*Medical documentation showing diagnosis of third degree burns over at least 20% of the body
Loss of Speech	<input type="checkbox"/>	*Medical documentation showing diagnosis of total loss of ability to speak for at least 180 days
Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	*Medical record documentation showing diagnosis of ALS

**Important: To avoid delay, please sign authorization below.**

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, provincial health insurance plan, government department or agency or other organization, institution or person, that has records or knowledge of me or my health to give to Allstate Insurance Company of Canada (AICC), their respective authorized plan administrators, representatives and/or producers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed, and I confirm that I am authorized to act on behalf of my dependent. This authorization shall remain valid for as long as I am claiming benefits, or until revoked in writing by myself. I or my representative may receive a copy of this authorization by supplying certificate number(s) and Insured's name in a written request to the company.

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_  Check here if address is new  
Claimant

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**SIGN THIS PART ONLY IF YOU WISH TO ASSIGN YOUR BENEFITS TO A PROVIDER OR A FACILITY**

I request that Allstate Insurance Company of Canada send benefits to someone other than me. Please send benefits available to the name and address shown below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Provider or Facility Identification Number \_\_\_\_\_ Address \_\_\_\_\_

City, Province, Postal Code \_\_\_\_\_

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_

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**ATTENDING PHYSICIAN'S STATEMENT**

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_

2. When did symptoms first appear or accident happen? Date: \_\_\_\_\_

3. When did patient first consult you for this condition? Date: \_\_\_\_\_

4. Has patient ever had same or similar condition? (If yes, state when and describe.)  Yes  No

5. Describe any other diseases or infirmity affecting present condition. \_\_\_\_\_

6. Nature of surgical or obstetrical procedure, if any (describe fully). \_\_\_\_\_

7. If patient is hospitalized, give name and address of hospital.

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

8. Date admitted: \_\_\_\_\_ Date discharged: \_\_\_\_\_

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**WAIVER OF PREMIUM (Answer this section if applicable.)**9. Is patient unable to perform job duties?  Yes  No If yes, from \_\_\_\_\_ through \_\_\_\_\_

10. What specific job duties is patient unable to perform? \_\_\_\_\_

11. Specific RESTRICTIONS (What the patient should not do and why). Please quantify in hours, weight, etc. \_\_\_\_\_

12. Specific LIMITATIONS (What the patient cannot do and why). \_\_\_\_\_

13. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? \_\_\_\_\_

14. Date patient last examined by you: \_\_\_\_\_ Frequency of visits:  Weekly  Monthly  Other \_\_\_\_\_15. Is patient:  Ambulatory  Bed Confined  House Confined  Other \_\_\_\_\_

16. When do you expect patient to resume partial duties? \_\_\_\_\_ Full duties? \_\_\_\_\_

17. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? \_\_\_\_\_

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**PHYSICIAN VERIFICATION**

Signed: \_\_\_\_\_, MD Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

# CLAIMS ADMINISTRATION DIRECT DEPOSIT AUTHORIZATION FORM

**TRANSACTION TYPE:**  New Setup  Cancellation  Change Financial Institution  Change Account Number

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## INSURED'S INFORMATION

Insured's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Certificate Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

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## FINANCIAL INSTITUTION

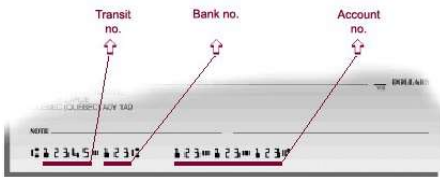
Financial Institution Name: \_\_\_\_\_  Checking  Savings

Financial Institution Address: \_\_\_\_\_

Account Number: \_\_\_\_\_ \*Electronic Routing Transit Number: \_\_\_\_\_

*\*Some banks use a separate routing number specifically for electronic ACH deposits. Please verify the routing number with your bank.*

**Note:** Only Canadian bank accounts are accepted.



## AUTHORIZATION AND SIGNATURE

I authorize Allstate Insurance Company of Canada (AICC) to initiate credit entries to the account number shown above for claims payment for all of my AICC certificates (unless benefits are assigned). I understand that AICC will make any adjustments, including the initiation of any credit or debit entries on the account, for the limited purpose of claims payment due to the account holder or due to AICC. Subject to local laws, AICC reserves the right to recover any credit entries made to my account in error.

Signing this Authorization will allow AICC to deposit claims payments for all eligible certificates underwritten by AICC.

Although direct deposit (Electronic Funds Transfer) is my preferred method of payment there may be circumstances which require a paper check to be issued as opposed to a direct deposit. I understand when I do business with AICC and/or its affiliates, parent and subsidiaries, the electronic documents, disclosures and electronic signatures may be utilized by AICC. This authority is to remain in full force and effect until AICC has received written notification revoking the authority. The financial institution information above is complete and accurate and is that of the certificate holder on file (unless the certificate holder is incapacitated or deceased). I understand I must notify AICC immediately if my financial institution or account information has changed by sending written notification to the address indicated below.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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**Submit the completed and signed authorization form with your claim form or send to:**

**Fax to:** 1-844-436-1107      **OR**      **Mail to:** Group Claims  
Allstate Benefits  
PO Box 8100 Stn T  
Ottawa, ON K1G 3H6

**Should you have any questions, please contact us at 1-844-436-1105.**