AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

CLAIMANT STATEMENT
Accidental Death

Name of Policyholder: N.D.T. Industry Health Benefit Plan **Policy No.:** GPA 9430271

1. a) Full name of the deceased:
   b) Address:
   c) Date of birth (MM/DD/YY): d) Employer's name:
2. a) Date of accident (MM/DD/YY): b) Circumstances:
3. a) Date of death (MM/DD/YY): b) Place of death:
   c) Cause of death:
4. a) Hospitalization dates (MM/DD/YY): From: To:
   b) Name of hospital:
   c) Name and address of family physician:

5. List insurance policies with other companies and policy numbers:

6. a) Please provide your full name:
   b) Date of birth if under the age of 18 (MM/DD/YY): (please attach a copy of birth certificate)
   c) Relationship to deceased:
   d) Capacity in which claim is being made: ☐ Beneficiary ☐ Executor (please submit proof)
   ☐ Assignee ☐ Other (explain):

PLEASE SUBMIT A COPY OF THE DEATH CERTIFICATE ALONG WITH THIS COMPLETED FORM

I am granting the following consent, authorization and direction regarding the personal information of (name) (the "Deceased") in my capacity as and concerning my interests or rights in such capacity.

PERSONAL INFORMATION NOTICE AND CONSENT: I understand that the information provided on this claim form and otherwise in respect of this claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess this claim, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of the Deceased's personal information, 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 this 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 this claim. I understand that the Deceased's personal information 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, this 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 the Deceased's former 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 this claim is 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 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 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 any group policyholder and employer , possessing records or knowledge of the Deceased to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about the Deceased or any other information or records about the Deceased in its possession that is requested while administering this claim. I agree that a photocopy of this authorization shall be as valid as 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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