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PHYSICIAN STATEMENT
Accidental Dismemberment

In this Physician Statement, "you" and "your" mean the Physician who completes it; "we", "us" and "our" mean AIG Insurance Company of Canada, the insurer providing **Accidental Dismemberment** *coverage.*

THE CLAIMANT IS RESPONSIBLE FOR ANY CHARGE INCURRED FOR COMPLETION OF THIS FORM.

1. a) Full name of patient:
   b) Date of birth (MM/DD/YY):

2. a) Is this condition a direct result of an accident? ☐ Yes ☐ No
   If yes, please provide cause and nature of sustained injury that led to the loss:

   b) Are there any underlying medical conditions that may have contributed to the loss? ☐ Yes ☐ No
   If yes, please explain:

   c) Date of accident (MM/DD/YY): d) Place of accident:
   e) Date of first attendance (MM/DD/YY):

3. Did the accidental injury result in:
   Loss of Hand(s): ☐ R ☐ L Severance was: ☐ Above/through wrist joint ☐ Below wrist joint
   Loss of Finger(s): ☐ R hand Fingers affected: ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Little
   ☐ L hand Fingers affected: ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Little
   Was severance through/above first (proximal) phalanx / phalanges of all affected fingers? ☐ Yes ☐ No
   Please explain:
   Loss of Foot/Feet: ☐ R ☐ L Severance was: ☐ Above/through ankle joint ☐ Below ankle joint
   Loss of Toe(s): ☐ R foot Toes affected: ☐ Big toe ☐ 2nd ☐ 3rd ☐ 4th ☐ Little
   ☐ L foot Toes affected: ☐ Big toe ☐ 2nd ☐ 3rd ☐ 4th ☐ Little
   Was severance through/above first (proximal) phalanx / phalanges of all affected toes? ☐ Yes ☐ No
   Please explain:
   Loss of Arm(s): ☐ R ☐ L Severance was: ☐ Above/through elbow joint ☐ Below elbow joint
   Loss of Leg(s): ☐ R ☐ L Severance was: ☐ Above/through knee joint ☐ Below knee joint
   Loss of Eye(s): ☐ R ☐ L

4. Was patient hospitalized? ☐ Yes ☐ No

If yes, provide dates hospitalized:

Provide hospital name(s) and address(es):

5. Names and addresses of other Physicians or Surgeons, if any, who attended the patient:

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

By signing below, you confirm that you understand and agree that the information you provide on this form becomes part of the patient's claim and that we may share that information with affiliates of AIG Insurance Company of Canada, the beneficiary or beneficiaries, applicable reinsurers, authorized third parties, including without limitation, third party service providers, and, where authorized by law, government entities, including financial services regulatory bodies and with other insurance companies to allow them to administer insurance with respect to the patient. Disclosures of information on this form will occur in accordance with AIG Canada's Privacy Principles available at www.aig.ca

Name of Attending Physician:

Address:

Signature of Attending Physician: Date (MM/DD/YY):

Phone number: Fax number:

The furnishing of forms shall not be an admission of liability by the AIG Insurance Company of Canada.

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