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

PHYSICIAN STATEMENT
Accidental Loss of Use

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 Loss of Use** *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):
   f) Date loss of use was diagnosed (MM/DD/YY):

3. Names and addresses of all physicians consulted or hospitals attended by patient for his/her condition (please **attach all medical records pertaining to this injury**)

Name of Physician / Hospital	*Address of Physician / Hospital*	*Date From:*	*Date To:*

4. Loss of Use:
   a) Which extremity or limb is affected - please be specific?
   b) Full details of loss of function:
   c) Has the Loss of Use been continuous for 12 consecutive months? ☐ Yes ☐ No
   d) Is the Loss of Use total, permanent and irrecoverable? ☐ Yes ☐ No

5. Loss of Sight:
   a) Has patient lost sight? ☐ No
   ☐ Yes, right eye ☐ Yes, left eye
   Date of loss (MM/DD/YY):
   b) Visual acuity: Right eye: Left eye: Both eyes:
   c) Is loss total and irrecoverable? ☐ Yes ☐ No

6. Loss of Hearing:

a) Has patient lost hearing? ☐ No

☐ Yes, right ear ☐ Yes, left ear

Date of loss (MM/DD/YY):

b) Auditory threshold: Right ear: dB Left ear: dB

c) Is loss permanent? ☐ Yes ☐ No

7. Loss of Speech:

a) Has patient lost speech (the ability to utter intelligible sounds)? ☐ Yes ☐ No

b) Date of loss (MM/DD/YY):

c) Is loss complete and irrecoverable? ☐ Yes ☐ No

8. Paralysis:

a) Type of paralysis: ☐ Monoplegia ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia

b) Affected limbs: ☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

c) Full details of loss of function:

d) Is paralysis complete and irreversible? ☐ Yes ☐ No

9. a) What is the prognosis?

b) Would there be any surgery or treatment that might improve this condition? ☐ Yes ☐ No

If yes, please explain:

10. Please provide any other information that would be helpful in the assessment of your patient's claim:

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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