ALLSTATE INSURANCE COMPANY OF CANADA
Accident Coverage with Optional Riders Claim Form

Mail or Fax Your Claim to:
Allstate Insurance Company of Canada Home Office
PO Box 8100, Stn T, Ottawa, Ontario, K1G3H6
Phone 1-844-436-1105 Fax 1-844-436-1107 or visit our website at https://mybenefits.allstatevoluntary.ca/

If you have any questions regarding policy benefits, the required documentation, or if you need assistance with your claim, please contact our Customer Care Center at 1-844-436-1105 or visit our website at https://mybenefits.allstatevoluntary.ca/

INSURED/PATIENT INFORMATION

POLICY NUMBER(S): _____ ; _____ ; _____ ; _____

INSURED INFORMATION:

First Name: _____ MI: _____ Surname: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Mailing Address: Street: _____ Apt #: _____ ☐ **Check here if address is new**

City: _____ Province: _____ Postal Code: _____

Phone #: (____) _____ E-mail: _____

PATIENT INFORMATION: (If different)

First Name: _____ MI: _____ Surname: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

CLAIM DETAILS

Please Provide the following Claim Details. This information is very important as it tells the examiner the specific details of your claim and helps the examiner determine eligibility of available benefits.

What are your **Diagnoses/Condition(s)** for this claim (list all): _____

Is your condition due to an **Accidental Injury**? ☐ Yes ☐ No Accident Date: _____ Time: _____ AM or PM

What was the **Accident or Event**? _____

What was the **Injury**? _____ ☐ Right side / ☐ Left side

Where did your accidental injury happen? _____

Tell us exactly **How** your accidental injury happened: _____

Have you ever had the same or similar condition? ☐ Yes ☐ No When? _____

Other Conditions affecting your health: _____

Was a **Police or Traffic Report** filed? ☐ Yes ☐ No (if yes, please provide) For Motor Vehicle Accidents, you were the: ☐ Driver ☐ Passenger

Is your condition Work Related? ☐ Yes ☐ No

Were you hospitalized due to this accidental injury? ☐ Yes ☐ No Admission Date: _____ Discharge Date: _____

Date of death: _____ Cause of death: _____

INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:

- *Benefits may vary by product. In addition, you may not have purchased all the Riders or have all the Benefits that are Listed. Please refer to your Coverage Document and riders for specific benefits available to you. An outline of your benefits is available on page 3 of your Coverage Document*.
- Please select the **Benefits** you believe may be due based upon the **Covered Person's Accidental Injury** and attach the **Required Documentation**.
- The required documentation needs to include the **Patient's Name, Diagnosis and Dates of Service**.
- If you are asked to provide **a bill** as required documentation, please ask your provider for: **an itemized bill**.
- You will be notified if additional information is needed.
- We also require you to sign and submit the Authorization to Release information to Allstate Insurance Company of Canada.

☐ ***NEW CLAIM*** ***or*** ☐ ***CONTINUED CLAIM***

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. Please check to be sure all information is correct before signing.

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CLAIMANT'S NAME: _____ **Date of Birth:** _____/_____/_____
POLICY NUMBER(S): _____ **Claim Number:** _____

ACCIDENT BENEFITS AND REQUIRED DOCUMENTATION	
☐ **Initial Hospital Confinement**	Inpatient hospital bill including Diagnosis and Room and Board Charges or Admission and Discharge Summaries
☐ **Brain Injury Diagnosis**	CT, MRI, EEG, PET scan, X-Ray report or Medical Records showing a Concussion, Cerebral Laceration, Cerebral Contusion or Intracranial Hemorrhage
☐ **Burn**	Bill or Medical Records documenting a 2nd or 3rd degree Burn (sunburn is not covered)
☐ **Eye Surgery**	Operative Report or Medical Record showing eye surgery or removal of a foreign object
☐ **Laceration**	Bill or medical record showing a laceration (deep cut).
☐ **Rehabilitation Unit**	Bill for inpatient rehabilitation immediately following hospitalization
☐ **Non-Local Transportation**	Documentation of non-local transportation 80+ km from the covered person's home when the same or similar treatment cannot be obtained locally
☐ **Family Member Lodging**	Bills for lodging 1 family member when the covered person is Hospital Confined and the family member lives 80+ km from the hospital
☐ **Accident Only Home Health Care / Long Term Care**	Bills or medical records documenting home health care or confinement to a long- term care nursing facility due to injuries sustained in a covered accident
☐ **Residence or Vehicle Modification**	Bills or documentation of permanent structural modification to the covered person's primary residence or vehicle, and medical records with physician certification that the modification is necessary due to injuries sustained in a covered accident.
☐ **Dislocation**	**Radiology Report or Medical Records showing a covered Dislocation:** ☐ Hip Joint ☐ Knee Joint (except patella) ☐ Bone or Bones of the Foot, other than toes ☐ Ankle Joint ☐ Wrist Joint ☐ Elbow Joint ☐ Shoulder Joint ☐ Bone or Bones of the Hand, other than Fingers ☐ Collar Bone ☐Two or more Fingers ☐ Two or more Toes ☐ One Finger or One Toe
☐ **Fracture**	**Radiology Report or Medical Records showing a covered Fracture:** ☐ Femur (Thighbone) ☐Skull (except bones of face or nose) ☐ Pelvis (except Coccyx) ☐ Upper Arm (Humerus) ☐ Shoulder Blade (Scapula) ☐ Lower Leg (Tibia or Fibula) ☐ Ankle ☐ Knee Cap (Patella) ☐ Collar Bone (Clavicle) ☐ Forearm (Radius or Ulna) ☐ Foot (except Toes) ☐ Hand or Wrist (except Fingers) ☐ Lower Jaw (except Alveolar Process) ☐Two or more Ribs, Fingers, or Toes ☐ Bones of Face or Nose ☐ One Rib, One Finger or One Toe ☐ Coccyx
☐ **Dismemberment**	**Operative Report or Medical Records showing covered Dismemberment:** ☐ Both Eyes ☐ One Eye ☐ Both Hands or Both Arms ☐ Both Feet or Both Legs ☐ One Hand or Arm & One Foot or Leg ☐ One Hand or One Arm ☐ One Foot or One Leg ☐ One or more Entire Toes ☐ One or more Entire Fingers
☐ **Functional Loss**	Documentation of Complete Loss of Hearing and/or Speech
☐ **Paralysis**	Documentation of Complete and Permanent Loss (Paralysis) of 2 or more Limbs
☐ **Accidental Death** ☐ **Common Carrier Accidental Death**	☐ Statement of Claim / Completed Claim Form ☐ Certified Copy of Death Certificate If Applicable, we may also need: ☐ Accident Report ☐ Autopsy Report ☐ Toxicology Report If additional information is needed you will be notified.
☐ **Life Enhancements – Air Bag Use**	Proof that the covered person's death, dismemberment or functional loss resulted from an injury that occurred while traveling in an automobile with an airbag for the covered person's seat.
☐ **Life Enhancements – Carjacking**	Proof that the covered person's death, dismemberment or functional loss resulted from an injury that occurred due to a carjacking while the covered person is the operator or passenger of the automobile. Verification must be part of an official report of the carjacking or be certified in writing by investigating officer(s).
☐ **Life Enhancements – Emergency or Disaster Response Team member**	Proof that the covered person's death, dismemberment or functional loss resulted from an injury that occurred while he or she is working for the policyholder and participating as a member of an emergency or disaster response team
☐ **Life Enhancements – Repatriation Expense**	Proof that the covered person's death, resulted from an injury that occurred at least 120 km from his or her principal residence, and proof of preparation and transportation of the body to a mortuary.
☐ **Life Enhancements – Seat Belt Use**	Proof that the covered person's death, dismemberment or functional loss resulted from an injury that occurred while traveling in an automobile and properly wearing a seat belt as defined in the Coverage Document.
☐ **Life Enhancements – Workplace Assault**	Proof that the covered insured's or covered spouse's death, dismemberment or functional loss resulted from an injury caused by a criminal assault by another person resulting in bodily harm while performing the usual and customary duties at the workplace or other places the employer requires travel.

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ACCIDENT BENEFITS AND REQUIRED DOCUMENTATION (Continued)	
☐ **Life Enhancements – Child Daycare**	Proof that the covered insured's or covered spouse's death resulted from a covered accidental injury, they have a dependent child under the age of 13 who is covered under the Certificate on the date of the covered accident, and the covered child is enrolled in a licensed child care provider within 60 days of the accident causing death, and expenses were incurred following the death. Provider cannot be an immediate family member.
☐ **Life Enhancements – Spouse Education or Training**	Proof of spouse's incurred training expenses if death results from a covered accidental injury and within 180 days of the accident, the spouse enrolls as a full-time student at an accredited education institution or vocational training institution preparing for full-time employment.

PROVIDERS: Please list all providers you have seen in the past two years including the providers treating you for this condition.

1. **Attending Physician's Name:** _____ Address: _____ Phone #: _____
   Specialty: _____ Dates Consulted: _____ Reason for Visit / Condition _____
2. **Primary Care Physician's Name:** _____ Address: _____ Phone #: _____
   Specialty: _____ Dates Consulted: _____ Reason for Visit / Condition _____
3. **Other Physician / Specialist Name:** _____ Address: _____ Phone #: _____
   Specialty: _____ Dates Consulted: _____ Reason for Visit / Condition _____
4. **Hospital Name:** _____ Address: _____ Phone #: _____
   Dates Hospitalized: _____ Reason for Hospitalization / Condition: _____

ASSIGNMENT OF BENEFITS

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

Name _____ Address _____

Provider's Tax Identification Number _____ City _____ Province _____ Postal Code _____

Relationship _____ Signature of Policy Owner _____ Date _____

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.

Claims submitted on dependents over 18 years of age require an authorization signed by the dependent.

I certify that the answers given on this claim form are true, complete, and correctly recorded.

Sign here: _____ Date: _____ ☐ **Check here if address is new**
Claimant

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Phone No.: _____

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