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 through https://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:_____

   Date of Birth: _____ ❑ Male ❑ Female

2. Daytime Phone Number: (____) _____ Evening/Cell Phone Number: (____) _____

3. 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 DESCRIBE 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 which you are requesting benefits)

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

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

1. Diagnosis: _____
2. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR
3. When did patient first consult you for this condition? Date ____/____/____ MO/DAY/YR
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: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR

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? ____/____/____ MO/DAY/YR Full duties? ____/____/____ MO/DAY/YR
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? ____/____/____ MO/DAY/YR

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ MO/DAY/YR Phone: (____) _____

Street Address: _____

City/Town: _____

State/Province: _____ Postal Code: _____