

## **GROUP CRITICAL ILLNESS CLAIM FORM**

If you have any questions regarding benefits available, how to file your claim, or if you would like to appeal any determination, please contact the Group CI Claims Department at: 1-519-725-7118 or 1-844-455-6255 8:00am to 7:00pm EST

The submission 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 complete in full the sections which apply to your specific claim, including your certificate number.

Claims can be remitted by: - faxed to: 1-519-669-5135

- scanned and emailed to: csr-allstate@rwam.com
- mailed to: Group CI Claims RWAM Insurance Administrators Inc., 49 Industrial Dr., Elmira, ON N3B 3B1

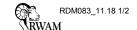
nsured's Name	Middle		Surname		C	ertificate #	
Group Name					G	roup #	
Email				tion		•	
Daytime Phone #							
Address				•			
CLAIMANT'S INFORMATION							
Claimant's Name					G	ender:   Male	□ Female
Relationship to Insured: ☐ Self ☐	Spouse	☐ Child		Date of Birth			Age
Please describe the nature and exten							
Date Critical Illness was diagnosed		Date symptoms first commenced					
f applicable, on what date was surge	ry performe	ed					
Please describe these symptoms							
On what date did you first consult a m	edical pra	ctitioner in o	connection v	vith your illness			
Name of Physician		Phone #					
Address							
# and Street		City/	Town	Prov.	Postal (	Code	

alth ent. tive authorized representatives, any and all such information necessary for any or all of the following purposes: to validate my coverage, investigate and confirm the accuracy and validity of my claim, determine my eligibility for benefit payments, administer my claim, and administer the group benefits plan and coverage.

I understand that my refusal or withdrawal of this authorization may delay claim adjudication or result in denial of my claim. I declare that all information provided in this Statement, and any other information I provide with my claim, or statements I make in any personal or telephone interview relating to this claim are/will be true, complete and

This authorization shall remain valid for the duration of my claim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Claimant's Signature X	Date		
Claimant's Name (please print)	* If claimant is under 18 years of age –Parent or Guardian signature is required		
* Parent/Guardian's Signature	Date		





# GROUP CRITICAL ILLNESS CLAIM FORM ATTENDING PHYSICIAN'S STATEMENT

## PATIENT INFORMATION – PLEASE NOTE THAT THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION.

### \*\* IMPORTANT \*\*

IN ORDER TO FACILITATE THE ASSESSMENT OF THIS CLAIM, PLEASE ATTACH ALL MEDICAL RECORDS, CONSULTATION REPORTS, TEST RESULTS, INVESTIGATIVE STUDIES, OPERATIVE REPORTS AND HOSPITAL RECORDS APPLICABLE TO THIS CONDITION.

Please complete all dates in Month/Day/Year format							
Patient's Name First Middle	Surna	ne	Date	of Birth			
PATIENT'S AUTHORIZATION		Croup #	Co	rtificate #			
Name of Patient (Please print)		Gloup #		Tillicate #			
I authorize the release of any medical informatio ("RWAM") and Allstate Benefits.	n requested related to	my claim for C	ritical Illness benefits to	RWAM Insurance Admi	nistrators Inc.		
Patient's Signature X			Date				
Diagnosis				-			
Other contributing factors?							
How long has the claimant been your patient?							
When did patient first consult with you on this condi	tion?	Da	te symptoms first appe	ared			
		Exact date of diagnosis					
Has the patient ever had the same or similar condition	ion? ☐ Yes	☐ No					
If 'Yes', state when, if applicable, the duration and c	lescribe						
Has the patient undergone surgery/operation/proce-	dure? ☐ Yes	□ No					
Please provide details							
Has the patient been hospitalized? ☐ Yes ☐	l No Length of	stay – from		to			
Name of hospital							
Since first visit, how often have you seen this patier	nt?   Weekly	☐ Bi-weekly	☐ Monthly ☐	1 Other			
Date last treated for condition		Date of next	treatment for condition				
Describe physical and/or psychological limitations (opsychological/cognitive problems)	e.g. physical restrictior	ns in range of m	otion; lifting, etc. and/or	limitations from depress	sion or other		
What major tasks of your patient's occupation is he	/she <i>able</i> to perform?						
What major tasks of your patient's occupation is hear	she <i>unable</i> to perform	n? (please list sp	pecifics that impair func	tional activity)			
What activities of daily living are impaired due to thi	s illness and how?						
Limitations - Patient is:□ Ambulatory □ House co	onfined   Bed confin	ed					
Prognosis - Patient is ☐ Recovered ☐ Not impr	oved 🗆 Improved	☐ Retrogress	ed Est. # of weeks be	efore possible return to w	ork wks.		
Have you discussed a return to work date with your	patient?	☐ Yes ☐ No	)				
If "Yes", return to work is planned at: $\Box$ <b>Own</b> Occ		ne, date	O Pa	rt-time, date			
□ Other Oc	•	ne, date	O Pa	rt-time, date			
If "No" discussion, please explain							
* Please ensure that you have attached all hosp	ital records, test resu	Its, consultatio	n notes and specialist	reports applicable to the	nis condition *		
ATTENDING PHYSICIAN'S INFORMATION							
Name of Attending Physician (please print)				Family Physician?	☐ Yes ☐ No		
Specialist?							
Telephone #		Fax #					
Address# and Street		City/Town	Prov.	Postal Code			
Physician's Signature X		•	Date				

