Allstate BENEFITS

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

INSURED AND CLAIMANT INFORMATION

Insured's Name _____ Certificate # _____
First Middle Surname

Group Name _____ Group # _____

Email _____ Occupation _____

Daytime Phone # _____ Evening Phone # _____

Address _____

CLAIMANT'S INFORMATION

Claimant's Name _____ Gender: ☐ Male ☐ Female
First Middle Surname

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child Date of Birth _____ Age _____

Please describe the nature and extent of the Critical Illness _____

_____

_____

Date Critical Illness was diagnosed _____ Date symptoms first commenced _____

If applicable, on what date was surgery performed _____

Please describe these symptoms _____

_____

On what date did you first consult a medical practitioner in connection with your illness _____

Name of Physician _____ Phone # _____

Address _____
and Street City/Town Prov. Postal Code

CLAIMANT'S AUTHORIZATION

I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, any insurance company, reinsurer, provincial health insurance plan, government department or agency, my employer or former employers, and any other person or organization having any relevant medical, employment, vocational, financial or other personal information or records regarding me to release to and exchange with RWAM Insurance Administrators Inc.("RWAM"), or their respective 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 accurate.

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 ✗ _____ ***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*** _____

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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 _____ Date of Birth _____
First Middle Surname

PATIENT'S AUTHORIZATION

_____ Group #_____ Certificate # _____
Name of Patient (Please print)

I authorize the release of any medical information requested related to my claim for Critical Illness benefits to RWAM Insurance Administrators Inc. ("RWAM") and Allstate Benefits.

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 condition? _____ Date symptoms first appeared _____

Exact date of diagnosis _____

Has the patient ever had the same or similar condition? ☐ Yes ☐ No

If 'Yes', state when, if applicable, the duration and describe _____

_____

Has the patient undergone surgery/operation/procedure? ☐ Yes ☐ No

Please provide details _____

_____

Has the patient been hospitalized? ☐ Yes ☐ No Length of stay – from _____ to _____

Name of hospital _____

Since first visit, how often have you seen this patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

Date last treated for condition _____ Date of next treatment for condition _____

Describe physical and/or psychological limitations (e.g. physical restrictions in range of motion; lifting, etc. and/or limitations from depression or other psychological/cognitive problems)

_____

What major tasks of your patient's occupation is he/she ***able*** to perform? _____

What major tasks of your patient's occupation is he/she ***unable*** to perform? (please list specifics that impair functional activity)

_____

What activities of daily living are impaired due to this illness and how? _____

Limitations - Patient is: ☐ Ambulatory ☐ House confined ☐ Bed confined

Prognosis - Patient is ☐ Recovered ☐ Not improved ☐ Improved ☐ Retrogressed Est. # of weeks before possible return to work _____ wks.

Have you discussed a return to work date with your patient? ☐ Yes ☐ No

If "Yes", return to work is planned at: ☐ **Own** Occupation - ❍ Full-time, date _____ ❍ Part-time, date _____

☐ **Other** Occupation - ❍ Full-time, date _____ ❍ Part-time, date _____

If "No" discussion, please explain _____

*** Please ensure that you have attached all hospital records, test results, consultation notes and specialist reports applicable to this condition ***

ATTENDING PHYSICIAN'S INFORMATION

Name of Attending Physician (please print) _____ Family Physician? ☐ Yes ☐ No

Specialist? ☐ Yes ☐ No If 'Yes', specialty is _____

Telephone # _____ Fax # _____

Address _____
and Street City/Town Prov. Postal Code

Physician's Signature ***X*** _____ ***Date*** _____

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