HOSPITAL CASH BENEFIT CLAIM FORM

Goose Insurance Services Inc.

Policy No. SRG9428332

INSTRUCTIONS FOR COMPLETING HOSPITAL CASH BENEFIT CLAIM FORM:

1. This form must be completed in full and signed by the Member.
2. A copy of the **Discharge Summary** from the Hospital must be attached to this claim form.
3. A copy of the **Hospital Invoice** confirming admission and discharge dates must be attached to this claim form.
4. This form and all attached bills must be submitted to the address indicated below.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

PLEASE PRINT AND INCLUDE ALL INFORMATION INDICATED.

Member Name		Date of Birth	MM DD YYYY	☐ Male ☐ Female
Member I.D. No.		Daytime Telephone No.	( ) -	
Address	Street		Ste. / Apt. No.	
	City	Province		Postal Code
Employer Name				

IF CLAIM IS FOR DEPENDENT, PLEASE PROVIDE THE FOLLOWING:

Dependent's Name		Date of Birth	MM DD YYYY	☐ Male ☐ Female
Dependent's Address	Street		Ste. / Apt. No.	
	City	Province		Postal Code
Relationship to Member				

Note: Eligible Members or dependents must be **admitted** to the hospital for a minimum of 72 hours to receive the Hospital Cash benefit. Your benefit payment will include the first 3 days, to a maximum of 120 days. Payment of this benefit will be equal to the total number of days as shown on the hospital discharge document. Hospital stays less than 3 days do not qualify for this benefit.

Dates Hospitalized From	MM DD YYYY	To	MM DD YYYY
Please provide diagnosis and why hospitalization was required			

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. **CERTIFICATION**: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim. **AUTHORIZATION**: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be as valid as the original.

	MM DD YYYY
MEMBERS SIGNATURE	**DATE**

	MM DD YYYY
SIGNATURE OF CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR	**DATE**

REMEMBER TO:

1. Complete all sections of the claim form.
2. Attach copy of **Discharge Summary**.
3. Attach copy of **Hospital Invoice (if available).**
4. Sign the claim form.

MAIL TO:

AIG Insurance Company of Canada
120 Bremner boulevard, Suite 2200
Toronto, ON M5J 0A8

AIG

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