



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 891 Member ID number.
- You may fax your claim to us at 1-844-436-1107 or scan and electronically submit your claim at <http://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: _____ 891 Member ID: _____

Date of Birth: _____ Male Female

2. Daytime Phone Number: _____ Evening/Cell Phone Number: _____

3. Employer's Name: _____ 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 DESCRIBES 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 for which you are requesting benefits.)

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

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: _____

3. When did patient first consult you for this condition? Date: _____

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: _____ Date discharged: _____

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? _____ Full duties? _____

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? _____

PHYSICIAN VERIFICATION

Signed: _____, MD Date: _____ Phone: _____

Street Address: _____

City/Town: _____

State/Province: _____ Postal Code: _____

