AIG Commercial Insurance Company Of Canada
145 Wellington Street West
Toronto, ON M5J 1H8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

CLAIMANT'S STATEMENT - PLEASE PRINT
Accident Claim Form

Policy Number: _____

Claimant's Surname: | Claimant's Given Name:

Address (Street & No.)

Apt./Unit No. | Telephone No.:

City/Town

Province | Postal Code

Date of Birth: D / M / Y | Sex: ☐ Male ☐ Female

1. Date of Accident:_____ Date of Initial Medical attention:_____
2. Full Details of Accident:_____
3. What injuries were sustained:_____
4. Name and Address of Family Physician:_____
5. Name and address of witness to this accident: _____
6. Name and Address of Surgeons or Specialists who provided treatment regarding this accident:
7. Please provide term of totally disability which prevented you from engaging in your pre-accident occupation (please attach supporting medical certification) From:_____To:_____

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 Commercial 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 Commercial Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial 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.

_____ _____

Signature of Insured or Insured's Parent/Guardian (if under age 18) | Date

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PHYSICIAN'S STATEMENT - PLEASE PRINT

Name of Patient: _____

Full description of injury sustained: _____

_____

Date of First Attendance: _____ Date of Actual loss: _____

Is loss permanent and irrecoverable? Give degree of loss _____

_____

Was claimant hospitalized? ( ) No, and if ( ) Yes- Give Hospital name, address and date admitted.

Is claim the direct result of an accident? ( ) No ( ) Yes

Did any disease or previous injury contribute to loss? ( ) No, and if ( ) Yes- Describe _____

_____

Name and address of other physicians or surgeons, if any, who attended claimant.

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ MD Date: _____

Attending Physician's Name (please print): _____

Address: _____

Phone Number: _____ Fax Number: _____