ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

CRITICAL ILLNESS BENEFIT
CLAIMANT STATEMENT

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No. _____

Name		
Phone # ( )		
Address		
City	Province	Postal Code
Sex ☐ Male ☐ Female	Date of Birth	
Health Insurance #		

CLAIM INFORMATION

Please describe the nature and extent of your Critical Illness:		
On what date was it diagnosed?		
If applicable, on what date was surgery performed?		
On what date did symptoms first commence?		
Please describe these symptoms:		
On what date did you first consult a medical practitioner in connection with your illness?		
Name of Physician	Phone # ( )	
Address		
City	Province	Postal Code
Have you undergone any tests or investigations related to this diagnosis? ☐ Yes ☐ No		
If yes, please provide details and dates:		
Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No		
If yes, please provide details and dates:		
Have you submitted a previous Critical Illness claim at anytime with any insurer? ☐ Yes ☐ No		
If yes, please provide details and dates:		

ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

CRITICAL ILLNESS BENEFIT
CLAIMANT STATEMENT

MEDICAL CONSULTATIONS

Name of your personal Physician		
Phone # ( )		
Address		
City	Province	Postal Code
Please provide details of any other doctors or specialists who have been consulted in connection with your illness:		
Name		Phone # ( )
Address		City
Province	Postal Code	Date seen
Name		Phone # ( )
Address		City
Province	Postal Code	Date seen
Name		Phone # ( )
Address		City
Province	Postal Code	Date seen
Name		Phone # ( )
Address		City
Province	Postal Code	Date seen
If you have been treated at a hospital or similar institution, please provide the following information:		
Name of Hospital		City or Town
Date of admission		Date of discharge
Name of Hospital		City or Town
Date of admission		Date of discharge
Name of Hospital		City or Town
Date of admission		Date of discharge
Name of Hospital		City or Town
Date of admission		Date of discharge
What other treatments have you received, and are you currently receiving, in connection with your illness? (e.g. medications, therapy, etc)		
Type of treatment		Institution
Prescribing Physician		Dates
Type of treatment		Institution
Prescribing Physician		Dates
Type of treatment		Institution
Prescribing Physician		Dates
Type of treatment		Institution
Prescribing Physician		Dates

ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

CLAIMANTS CERTIFICATION: The above statements 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 without refund of any premiums paid 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.

PRIVACY NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by ACE INA Insurance and/or ACE INA Life Insurance, 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. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons I may authorize.

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, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with ACE INA Insurance/ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment 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 photocopy of this authorization shall be as valid as the original.

Claimant Name (please print)
Signature
Date