LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

ACCIDENTAL DEATH (BASIC)

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

ACCIDENTAL DEATH (BASIC)

SUBMISSION INSTRUCTIONS:

- Member/Beneficiary to complete and sign the Claimant's Statement and Authorization Form (or Power of Attorney, if applicable).

- Attending Physician to complete and sign the Physician's Statement.

- Include any supporting documentation (ie. police records, medical records, etc.). Please keep a copy of complete application package for you records to substantiate your claim.

- Policy No. ABT10241001.

- Send completed application and supporting documents via fax, e-mail or mail to:

LiUNAcare Local 183
1263 Wilson Avenue, Suite 205
Toronto, ON M3M 3G2

Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line: 1-888-790-3534
Email: info@liunacare183.com

CHUBB®

PROOF OF ACCIDENTAL DEATH
CLAIMANT'S STATEMENTS

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

ATTACH CERTIFIED COPY OF DEATH CERTIFICATE
PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No.			
1.	**Full name of Deceased:**		
2.	**Full address of the Deceased at death:** **Street Address:**		
	City:	**Province:**	**Postal Code:**
3.	**Date of birth of Deceased:**		
4.	**Please, date and time of death:**		
5.	**(a) Occupation of Deceased at death:**		
	(b) Name and address of Employer: **Street Address:**		
	City:	**Province:**	**Postal Code:**
6.	**(a) On what date did the accident occur?**	**(b) Approximate time of accident:**	
	(c) Specifically, where did the accident occur?		
7.	**How did the accident occur? (answer fully)**		
8.	**Who was present at the time of the accident? (Witness) Please list names and addresses.**		
9.	**What injury or injuries were sustained?**		
10.	**Was an Autopsy or Inquest held? ☐ Yes ☐ No**		
	If yes, give the name of the agency called and attach a copy of the report if available to you.		
11.	**Were the police called to the scene of the accident? ☐ Yes ☐ No**		
	If yes, give the name of the agency called and attach a copy of the report if available.		
12.	**(a) State name and address of the doctor or Hospital that first attended after the injury.**		
	(b) Also, name and address of the doctor or hospital that attended the Deceased at the time of death.		

13. Did the Deceased have a family doctor? ☐ Yes ☐ No If yes, give the doctor's name and address.	
14. Did the Deceased see a doctor for an injury or sickness in the last two years? ☐ Yes ☐ No If yes, when and what for?	
Give the doctor's name and address.	
15. Did the Deceased carry any other Accident or Life Insurance?	
If so, state the name of the Insurer:	
Address:	
Policy Numbers:	
Amounts Carried:	
(a) What is your full name?	**(b) Date of birth:**
(c) Relation to the Deceased?	
16. Your Social Insurance # (required for tax purposes):	
17. Remarks	

Claimant's 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 Chubb Insurance and/or Chubb 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 as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit chubb.com/ca or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

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 Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

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

Full Mailing Address of Claimant:		
Address:		
City:	**Province:**	**Postal Code:**
Phone # of Claimant ( )		

Signature of Claimant _____ Date _____

CHUBB®

AUTHORIZTION TO OBTAIN INFORMATION (DECEASED)

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

Name of Insured: _____

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning the late

_____

to give to Chubb Insurance or Chubb Life Insurance Company of Canada all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance Company of Canada in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as

_____

and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance Company of Canada, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance Company of Canada requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this authorization shall be as valid as the original.

Name (Please Print) _____ Signature _____

Dated at _____ of _____
City/Town Region/Municipality

In the Province of _____ on this _____day

of _____.
Month and Year

Signature of Patent/Guardian if Child is a Minor _____

CHUBB®

PROOF OF ACCIDENTAL DEATH
ATTENDING PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION

Full Name of Deceased:		
Date of Birth:	**Sex:** ☐ **Male** ☐ **Female**	
Address:		
City:	**Province:**	**Postal Code:**
Date of Death:		
Place of Death (if Hospital or Institution, give name):		

CAUSE OF DEATH

1. State the Disease, Injury or Complication which caused Death, not mode of dying, such as Heart Failure, etc.
2. Antecedent Causes: Morbid Conditions, if any, giving rise to the above cause stating the underlying cause last.
3. Other Morbid Conditions contributing to Death, not related to the condition causing Death.
4. To what extent did any antecedent causes contribute to Death?
5. If Death was due to accident, Suicide or homicide, specify which. Describe briefly and include dates.
6. Was an Inquest held? ☐ **Yes** ☐ **No**
Was an Autopsy performed? ☐ **Yes** ☐ **No**
If so, by whom and with what findings?
How was this death said to have been caused?

7. When and where did you first attend the Deceased for this matter?
8. Was the injury described above, directly and independently of all other causes, sufficient to produce Death?
9. Have you treated or advised the Deceased during the last 3 years? ☐ Yes ☐ No
Did the Deceased, to your knowledge, receive treatment during the last 3 years from any other Physician, or in any Hospital or Institution? ☐ Yes ☐ No
If "Yes" to either question, please furnish the following:
Name:
Address:
Nature of Illness or Injury:
Date:
Name:
Address:
Nature of Illness or Injury:
Date:

The answers I have made to the above questions are true and complete to the best of my knowledge and belief.

Name of Physician completing this form (please print): _____

Signature of Physician completing this form: _____ Date: _____

Office Address:	
Phone #: ( )	**Fax #: ( )**

CHUBB

PROOF OF DEATH
PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

PART A – INFORMATION ABOUT THE DECEASED

Policy No:		
Last Name:	**First Name:**	
Date of Birth:	**Date of Death:**	
Address:		
City:	**Province:**	**Postal Code:**
Place of Death:	**Cause of Death:**	
Date of First Visit of the Last Illness:	**Date of Last Visit of the Last Illness:**	

Immediate cause of death (disease, injury or complication causing death) :	
Time between onset and death:	
List any other significant conditions whether or not related to the cause of death:	
Was death due to: ☐ **Accident** ☐ **Suicide** ☐ **Homicide** ☐ **None of the Above**	
Briefly describe:	
Was autopsy performed: ☐ **Yes** ☐ **No**	**Who performed the autopsy:**
What were the results of the autopsy:	

LIST THE TIMES THAT YOU ATTENDED TO THE DECEASED IN THE LAST TWO YEARS

Date of Visit	Nature of Illness

LIST THE TREATMENTS RECEIVED BY THE DECEASED IN THELAST TWO YEARS FROM OTHER PHYSICIANS, HOSPITALS OR INSTITUTIONS

Physician's Name	Address	Date of Visit	Nature of Illness

PART B – DECLARATION & SIGNATURES

I declare that these statements are complete and true to the best of my knowledge.

Name of Physician:	**Date:**	
Phone # of Physician: ( )	**Fax # of Physician: ( )**	
Address of Physician:		
City:	**Province:**	**Postal Code:**

Signature of Physician _____ Date _____

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION