LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

HOSPITAL CASH

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

HOSPITAL CASH

SUBMISSION INSTRUCTIONS:

- Member to complete and sign the Hospital Cash benefit claim form;
- Include your hospital discharge summary indicating reason for hospitalization and diagnosis. Please keep a copy of completed application package for your records to substantiate your claim.
- Policy No. SG10395001.
- Send completed application and supporting documents via fax, email or mail to:

LiUNAcare Local 183
2100 – 200 Labourers Way
Vaughan, ON L4H 5H9

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

CHUBB

HOSPITAL CASH BENEFIT CLAIM FORM
L.I.U.N.A. LOCAL 183
MEMBERS TRUST FUND
POLICY NUMBER: SG 10395001

Chubb Life Insurance Company of
Canada c/o LiUNAcare Local 183
2100 – 200 Labourers Way
Vaughan, ON L4H 5H9

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

INSTRUCTIONS FOR COMPLETING HISPITAL 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. If available, the original copy of the **Hospital Invoice** confirming admission and discharge dates can be attached to this claim form.
4. This form and all attached bills must be submitted to the address indicated below.
5. Please retain a copy for your records.

PLEASE PRINT AND INCLUDE ALL INFORMATION INDICATED:

Member Name:	**Date of Birth:**	**Sex: ☐ Male ☐ Female**
Member I.D. No.:	**Daytime Telephone No.: ( )**	
Address:		
City:	**Province:**	**Postal Code:**
Employer Name:		

IF CLAIM IS FOR DEPENDENT, PLEASE PROVIDE THE FOLLOWING:

Dependent's Name:	**Date of Birth:**	**Sex: ☐ Male ☐ Female**
Dependent's Address:		
City:	**Province:**	**Postal Code:**
Relationship to Member:		

Note: Eligible members or dependents must be hospitalized 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. Hospital stays less than 3 days do not qualify for this benefit.

HOSPITALIZATION DETAILS:

Name of Hospital:		
Address:		
City:	**Province:**	**Postal Code:**
Dates Hospitalized From:	**Dates Hospitalized To:**	
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.

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.

Member's Signature _____ Date _____

Signature of Claimant or Parent, if Claimant is a Minor _____ Date _____

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 remember to follow all of the instructions outlined at the top of this form.

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

FOR OFFICE USE ONLY ADMINISTRATOR AUTHORIZATION COMPLETED BY LiUNAcare LOCAL 183	
Member's Name:	**Member's I.D. No.:**
Claimant's Name:	**Relationship to Member:**
Claimant's Effective Date:	**Claimant's Termination Date (if applicable):**
Amount of Cash Benefit: $ / day	
Administrator's Name (Please Print):	
Administrator's Title:	
Daytime Telephone No.: ( ) Ext.	

Administrator's Signature _____ Date _____