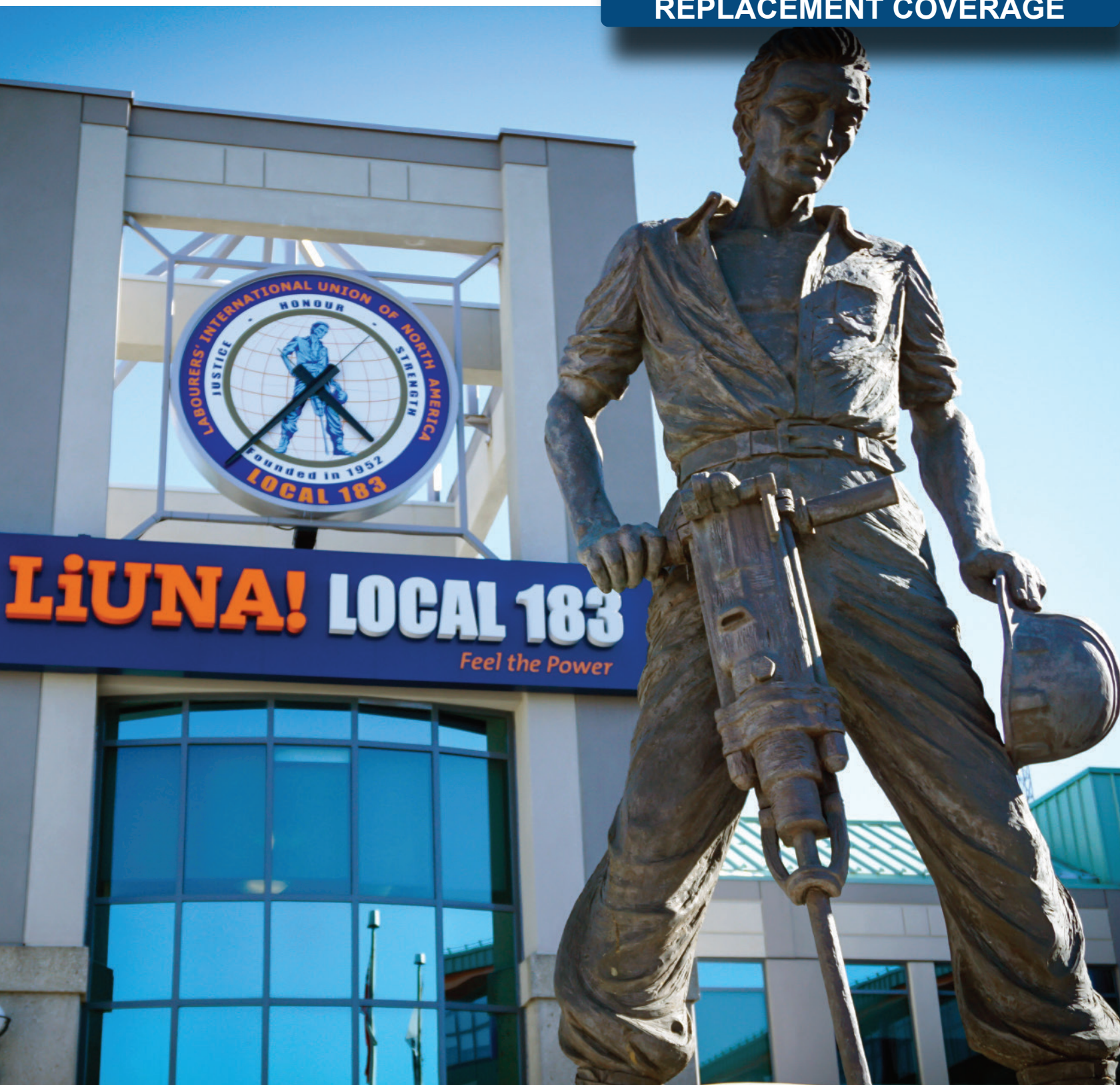
LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

PROVINCIAL MEDICAL REPLACEMENT COVERAGE



LiUNA LOCAL 183
MEMBERS BENEFIT FUND

PROVINCIAL MEDICAL REPLACEMENT COVERAGE

SUBMISSION INSTRUCTIONS:

- Member & Physician to complete and sign the Provincial Medical Replacement claim form.

- Include all invoices and receipts (originals required). Please keep a copy of completed application package for your records to substantiate your claim.

- Policy No. SRG9114253.

- Send all original completed applications 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

AIG Insurance Company Of Canada
c/o LiUNAcare Local 183
2100 – 200 Labourers Way
Vaughan, ON L4H 5H9
416-240-7480

PROVINCIAL MEDICAL REPLACEMENT CLAIM FORM

PLEASE PRINT

POLICYHOLDER'S NAME**:** _____

POLICY NUMBER**:** _____ DATE OF BIRTH

INSURED'S NAME _____ (SURNAME) _____ (FIRST NAME) SEX ( ) | D | M | Y |

I.D. NUMBER _____ DATE OF BIRTH

PATIENT'S NAME: _____ (SURNAME) _____ (FIRST NAME) SEX ( ) | D | M | Y |

I.D. NUMBER _____

FULL ADDRESS IN CANADA _____ STREET BUS. PHONE NO. ( )_____

_____ CITY PROVINCE POSTAL CODE

TYPE OF COVERAGE: INSURED ( ) SPOUSE ( ) DEPENDENT ( )

(A) THIS SECTION TO BE COMPLETED IF CLAIMING FOR PRESCRIPTION DRUGS, PARAMEDICAL SERVICES, X-RAYS OR LABORATORY FEES.

Name of Patient	Date Service Rendered	Nature of Illness or injury	Claim Description	Amount Charged	Name of Doctor Prescribing Service

CHEQUE SHOULD BE PAYABLE TO: ( ) INSURED OR ( ) OTHER (Indicate below)

PLEASE PRINT

NAME: _____

ADDRESS:_____

_____ CITY PROVINCE POSTAL CODE ( )_____ PHONE NO.

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 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 Insurance Company of Canada, or representatives thereof, all personal health information and benefit payment 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.

Date :_____ Insured's signature :_____

PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS

SEE REVERSE SIDE FOR PHYSICIAN'S STATEMENT

(B) YOUR PHYSICIAN MUST COMPLETE THIS SECTION IF CLAIMING FOR HOSPITAL, MEDICAL EXPENSES OR PHYSICIAN SERVICES

PHYSICIAN ACCOUNT RECORD COMPLETE

Diagnosis (describe complications, if any) and Procedures - Use exact wording of schedule of fees

Service Code	Fee Submitted	Number Of Services	Service Date D / M / Y	Diagnostic Code	Service Code	Fee Submitted	Number Of Services	Service Date D / M / Y	Diagnostic Code

Your total charge for these visits - at office $_____ Hospital $_____ Home $_____ TOTALS $_____

I DECLARE THAT THE ABOVE IS A CORRECT STATEMENT OF SERVICES PERSONALLY RENDERED BY ME.

SIGNED THIS: _____ DAY OF _____ 19_____ AT _____

PHYSICIAN'S NAME: _____ ADDRESS: _____

PHYSICIAN'S SIGNATURE: _____ _____

CITY PROVINCE POSTAL CODE

MD ( ) Certified Specialist? ( ) TELEPHONE NUMBER ( ) _____

(C) DENTAL - IF YOU SUSTAINED DENTAL INJURY AS THE RESULT OF AN ACCIDENT AND ARE CLAIMING ACCIDENT RELATED DENTAL EXPENSES, PLEASE PROVIDE THE FOLLOWING:

DATE OF ACCIDENT: _____ DATE OF INITIAL DENTAL ATTENTION: _____

Please attach a standard dental claim form, available in your dentist's office, fully completed and signed by your dentist for the accident related dental treatment received.

FULL DETAILS OF ACCIDENT: _____

WHAT INJURIES WERE SUSTAINED: