Return to:
Alberta Lacrosse Association
9 Chippewa Road, Unit 4
Sherwood Park, Alberta T8A 6J7

AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
ahclaimscan@aig.com

ALBERTA LACROSSE ASSOCIATION CLAIM FORM – EMM 9150758

INSTRUCTIONS: Please complete, sign, attach all original receipts and remit to Alberta Lacrosse Association promptly. Failure to provide the requested claim documentation could affect our ability to process your claim in a timely manner. Kindly retain a copy of your claim for future reference. Questions concerning your claim can be emailed to: AHClaimscan@aig.com or by calling 1-877-317-8060 (Canada & USA).

SECTION A INSURED'S INFORMATION

Last Name: First Name:

Date of Birth: MM/DD/YYYY ☐ Male ☐ Female **E-mail:**

Address in Canada: Street Name and Number Apt. :

City: Province: Postal Code:

Home Phone No.: Other Phone No.:

Temporary Address:

Patient's Health Card No: Verification Code:

SECTION B TRAVEL DETAILS

Departure Date: MM/DD/YYYY Return Date: MM/DD/YYYY Mode of Travel: ☐ Car ☐ Airplane Other:

Destination(s):

SECTION C OTHER INSURANCE INFORMATION

Do you have any other Insurance Coverage? (check all that apply- include required information)

☐ Spouse ☐ Travel ☐ Hospital/ Medical ☐ Home/Auto ☐ Other:_____ ☐ I have no other Insurance

Name of Insurance Company:

Address: Phone #:

Policy No.: Certificate/ID # :

Do you have a credit card which provides out-of-country medical coverage? ☐ YES ☐ NO
If Yes: Name of Insurance Company:

Address: Phone # :

Policy No.: Certificate/ ID #: Card # :

Have these bills been filed with any other company? ☐ YES ☐ NO

SECTION D MEDICAL INFORMATION/ CLAIM DETAILS

Date of initial onset of illness or injury: YYYY / MM / DD Diagnosis:

Details of occurrence: Location:

Was medical treatment required as a result of an accident or due to an emergency? ☐ Accident ☐ Emergency Other:

Were you advised to seek treatment for this condition in a place other than your normal province of residence? ☐ YES ☐ NO

If yes, please explain:

Were you hospitalized? ☐ YES ☐ NO If yes, advise date of admission: YYYY / MM / DD date of discharge: YYYY / MM / DD

Name of Hospital: Phone # :

Address of Hospital:

Have you had any of these conditions before? ☐ YES ☐ NO If yes, indicate the date your were **last** treated: YYYY / MM / DD

Name of Family Physician: Phone # :

Address:

Name of First Physician Consulted: Phone # :

Address:

Total Amount being claimed: $ **Currency:**

SECTION E AUTHORIZATION AND RELEASE

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

Signature: Date:

CHEQUE SHOULD BE PAYABLE TO:

☐ Insured at the above address ☐ Parent/Guardian ☐ Provider ☐ Alberta Lacrosse ☐ Other (complete following)

Payable to:

Address: Street Name and Number Apt.# :

City: Province: Postal Code:

Insured's signature: **Date**:

SECTION F Association's Statement – *To be completed by Alberta Lacrosse Association*

Name of the Insured: Event: Location:

Departure Date: Scheduled Return Date:

Date of initial onset of illness or injury: Details of occurrence:

Name: Email: Telephone No.:

Date: Signature:

PLEASE REMEMBER TO ATTACH ALL ORIGINAL RECEIPTS

Mail to: Alberta Lacrosse Association
9 Chippewa Road, Unit 4
Sherwood Park, AB T8A 6J7