AIG Insurance Company Of Canada
145 Wellington Street West
Toronto, ON M5J 1H8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

CANADIAN CAMPING CLAIM FORM

PLEASE PRINT

POLICY NUMBER**:** _____ CAMP'S NAME: _____

ADDRESS OF CAMP: _____

PHONE # ( ) _____ FAX# ( ) _____

Please attach a copy of the completed Incident/ Accident Report related to this event (if available).

Name of Insured Person First Last	Date of Birth MM/DD/YY	Canadian Citizen Yes/No	Employee – E Volunteer – V Camper - C	Date of Loss MM/DD/YY	Diagnosis	Total Amount

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 INITIAL DENTAL TREATMENT: _____

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:

_____

_____

MEDICAL AUTHORITY

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-coordinating 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:_____Authorized Camp Representative Signature:_____

PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS

Note: The claims payment will be made to the Camp unless indicated below.

NAME: _____ PHONE # ( ) _____

ADDRESS: _____