CRITICAL ILLNESS CLAIM FORM

MSH INTERNATIONAL 2020

Group Name	Policy Number
HealthSure Program	**BA1052**

Important: An Insured Person is not entitled to the Critical Illness Benefit unless they survive for 30 days following the Date of Diagnosis or such longer period as described in Certain Covered Critical Illness Conditions in their policy.

SECTION A: CLAIMAINT INFORMATION

First Name | Last Name | Middle Initial

Date of Birth (MM/DD/YYYY) | Certificate Number

Address

City | Province/State | ZIP/Postal Code | Country

Phone Number (include country code) | Email Address

SECTION B: CLAIMANT MEDICAL INFORMATION

Nature of Illness or Surgery

Description of Initial Symptoms

Date Symptoms First Appeared (MM/DD/YYYY) | Date of Diagnosis Established by a Physician or Date of Surgery (MM/DD/YYYY) | Date of First Consultation (MM/DD/YYYY)

Name of Family Physician

Address of Family Physician

City | Province/State | ZIP/Postal Code | Country

Names of physicians consulted (if unknown, state the name of the clinic or hospital)	**Date** (MM/DD/YYYY)	**Address**	**Reason**

Have you, or any member or your family, ever suffered from this condition? If so, complete the information below:

Relationship to Insured	**Nature of Illness**	**Date** (MM/DD/YYYY)

Have you submitted a claim to another insurance company for this condition? ☐ Yes ☐ No
If yes, please provide:

Name of Company/Contact | Address of Company/Contact | Policy Number

Do you use tobacco products? ☐ Yes ☐ No If Yes, since when? ____________________

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I hereby warrant the truth of all statements on this form and give MSH INTERNATIONAL permission to contact the medical attendants directly, if required. I agree to supply further information, medical or otherwise, required to complete the assessment of this claim.

Signature: Date (MM/DD/YYYY):

SECTION C: ATTENDING PHYSICIAN'S STATEMENT

Patient's Name | Date of Birth (MM/DD/YYYY) | Date Symptoms First Appeared (MM/DD/YYYY)

Nature of Illness

Has the patient ever suffered from a similar condition?

Description of symptoms

Date of First Consultation (MM/DD/YYYY) | Date of Diagnosis (MM/DD/YYYY)

Name of physicians who referred the patient to your attention or to whom you have referred the patient:

Name	Clinic or Hospital

This form will be used to open a file in order to determine if the insured person is entitled to a Critical Illness Benefit. The covered illnesses are indicated in the policy. If the conditions are met, MSH INTERNATIONAL (CANADA) LTD. will contact you to obtain additional information related to the illness using the authorization form signed by the insured. If you require a specific form for the authorization, please attach it to this form.

Name of Attending Physician

Address of Attending Physician

City | Province/State | ZIP/Postal Code | Country

Phone Number (including area and country codes)

Signed at: ______________________ Date (MM/DD/YYYY): ______________

Physician's Signature: ______________________

SUBMIT CLAIMS TO

MSH CANADA: 300, 999-8TH S.W. | Calgary, AB T2R 1N7 CANADA