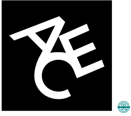


**ACE INA Insurance**
**ACE INA Life Insurance**
1400 – 25 York Street
**Toronto, Ontario** M5J 2V5
**Telephone: 416-594-2627 1-877-772-7797**

# CANADIAN ACTORS' EQUITY ASSOCIATION ACCIDENT & SICKNESS INSURANCE APPLICATION FOR INCOME REPLACEMENT BENEFITS

**EQUITY MEMBER TO SUBMIT COMPLETED FORM DIRECTLY TO ACE INA LIFE INSURANCE**

**PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT**

**IDENTIFICATION - TO BE COMPLETED BY EQUITY MEMBER**

**Please check off appropriate Policy Number** ☐ **SGC 100005 Base Plan** ☐ **SGC 102067 Enhanced Plan**

| Full name of Claimant | | Member Number: |
|---|---|---|
| Address | | |
| City | Province | Postal Code |
| Phone # ( ) | | |
| Date of Birth | Sex ☐ Male ☐ Female | |

| Briefly describe the role or duties including physical requirements: |
|---|
| |
| |
| |

**CLAIMANTS 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 t**hat 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 ACE INA Insurance** and/or **ACE INA 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 e**ffect, **investigating the applicability of exclusions and coordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and** fr**om 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 I may authorize.**

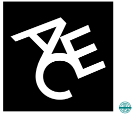
**AUTHORIZATION: I authorize,** for **a period of not less than twelve and not more than twenty-four months** fr**om the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, 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 ACE INA Insurance/ACE INA Life Insurance, or representatives thereof, all personal health information, benefit payment or financial 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 photocopy of this authorization shall be as valid as the original.**

**Name of Member** (please print) ________________________________

**Signature of Member** ________________________________

**Date** ________________________________



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**CANADIAN ACTORS' EQUITY ASSOCIATION
ACCIDENT & SICKNESS INSURANCE
APPLICATION FOR INCOME REPLACEMENT
BENEFITS**



## MEDICAL ATTENTION STATEMENT - TO BE COMPLETED BY MEMBER

| | | |
|---|---|---|
| Name of Attending Physician | Date of first medical attention | |
| Address | | |
| City | Province | Postal Code |
| If hospitalized, name of Hospital | | |
| From | To | |
| If disabled, date you were first unable to work because of this disability ☐ AM ☐ PM | | |
| If you have returned to work, give date returned ☐ AM ☐ PM | | |
| In the case of an accident, date of the accident | Did the accident happen at work while under contract? ☐ Y ☐ N | |
| How did it happen? | | |
| | | |
| | | |

## DETAILS OF ACCIDENT/ILLNESS - TO BE COMPLETED BY EQUITY ENGAGER

| | | |
|---|---|---|
| Full name of Engager | | |
| Address | | |
| City | Province | Postal Code |
| Phone # ( ) | Fax # ( ) | |
| Member's name | Name of Production | |
| On what date did He/She cease work entirely? | | |
| On what date did He/She resume any part of His/Her work? | | |

Signature of Engager ________________________________

Date ______________________________________________

## EQUITY MEMBER TO SUBMIT COMPLETED FORM DIRECTLY TO ACE INA LIFE INSURANCE

**A CANADIAN ACTORS' EQUITY ASSOCIATION ACCIDENT & SICKNESS INSURANCE APPLICATION FOR INCOME REPLACEMENT BENEFITS ATTENDING PHYSICIAN'S STATEMENT MUST BE SUBMITTED WITH THIS COMPLETED FORM**