HOSPITAL CASH BENEFIT CLAIM FORM

Canadian Piping Trades LOCAL 67

ARDENT ASSISTANCE

Administered by: Ardent Assistance Inc.
25 Millard Avenue West, Newmarket, ON L3Y 7R6
Telephone: 416-285-1722

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

INSTRUCTIONS FOR COMPLETING HOSPITAL CASH BENEFIT CLAIM FORM:

- Claims must be submitted within 30 days of the date of the hospitalization.
- This form must be completed in full and signed by the Member and Claimant(s) where indicated for each new hospitalization.
- Submit a copy of the discharge summary along with a copy of the hospital invoice within 90 days from date of discharge.
- Provide additional information pertinent to the insured person's claim, as may be required by the insurer after receipt of the claim; and if so required, furnish a certificate as to the cause and nature of the sickness, accident or injury, for which the claim is made and as to the duration of the hospitalization.
- This form and all attached bills must be submitted to the address indicated below.
- Please retain a copy for your records.

Note: Eligible members or dependents must be hospitalized for a minimum of 72 hours to receive the hospital cash benefit. Your benefit payment will include the first 3 days to a maximum of 120 days. Hospital stays less than 72 hours do not qualify for this benefit.

PRINT AND INCLUDE ALL INFORMATION INDICATED:

Member Name:	Date of Birth:	( ) Male ( ) Female
Member I.D. No.:	Daytime Telephone No.: ( )	
Street Address:		
City:	Province:	Postal Code:
Employer Company Name:		

IF CLAIM IS FOR DEPENDENT, PLEASE PROVIDE THE FOLLOWING:

Dependent's Name:	Date of Birth:	( ) Male ( ) Female
Dependent's Address:		
City:	Province:	Postal Code:
Relationship to Member:		

Name of Hospital:			
Hospitalization Date:	From:	To:	
Address:			
City:	Province:	Postal Code:	
Reason for hospitalization and diagnosis:			

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LOCAL 67

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I hereby certify that all information given is true and correct to the best of my knowledge and belief.

Claimant's 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 that such amounts should not have been paid in respect of my claim.

Signature of Insured (if a minor, signature of a parent or legal guardian) _____

Name of Parent/Legal Guardian, if applicable:_____ Date signed:_____

PRIVACY AND DECLARATION

Ardent Assistance Inc. Privacy Statement

Ardent Assistance is committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that it collects, uses, retains, and discloses in the course of conducting business.

At Ardent Assistance, we recognize and respect the importance of privacy. When you enroll for insurance coverage or submit a claim, we establish a confidential file and collect, use, and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about Ardent Assistance's privacy policy at www.ardentassistance.ca. If you have any questions regarding our privacy practices, please contact the Privacy Officer at:

Ardent Assistance Inc.
25 Millard Avenue West,
Newmarket, Ontario L3Y 7R6
Telephone: 416-285-1722
E-Mail: info@ardentassistance.com

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention, and disclosure of my personal information or those of my dependents for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there are medical and/or file materials that have not been provided, or suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Ardent Assistance may investigate on behalf of Berkley Insurance Company to request and obtain any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of establishing eligibility or of investigating and preventing fraud and/or plan abuse.

HOSPITAL CASH BENEFIT CLAIM FORM

If I receive payment from Ardent Assistance in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to Ardent Assistance and Berkley Insurance Company for such overpayment; (b) Ardent Assistance and Berkley Insurance Company has the right to recover the overpayment amount through any means available by law; and (c) Ardent Assistance and Berkley Insurance Company will offset any benefits payable to me by the overpayment amount until the overpayment amount is recovered in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Direction and Authorization

By signing this form, I hereby authorize and direct any employer, union, association, physician, health care facility, treatment provider, plan administrator, any insurance company, reinsurer, provincial health insurance plan, government department (collectively, "Third Party") having medical or other relevant personal information regarding me, my spouse and/or dependent to disclose, release, share and exchange information with Ardent Assistance, its underwriter, plan administrator, agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. I am authorized to act on behalf of my dependents for these purposes. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

Full Name of Patient _____ Date: _____

I authorize payment of this claim to (print name): _____

Signature of Insured (if a minor, signature of Parent/Legal Guardian) _____

HOSPITAL CASH BENEFIT CLAIM FORM

HOSPITAL CASH BENEFIT CLAIM FORM
GOVERNING LAW AND EXCLUSIVE JURISDICTION AGREEMENT

Print Name of Person or Dependent in Hospital ("**Claimant(s)**"):_____

(If applicable) Guardian for above Person (collectively also "**Claimant(s)**")_____

This Governing Law and Exclusive Jurisdiction agreement (the "GLEJ agreement") is between the above noted Claimant(s) and Berkley Insurance Company/Ardent Assistance Inc. (collectively the "Claims Adjudicators").

GOVERNING LAW

The Claimant(s) and the Claims Adjudicators agree that all aspects of the relationship between the Claimant(s) and Claims Adjudicators and the resolution of any and all disputes or arbitrations arising from or in connection with that relationship, including any disputes arising under or in connection with this GLEJ agreement shall be governed by the law of the Canadian province or territory of residence of the Claimant(s). All disputes shall be resolved by arbitration. The costs of any arbitrator and arbitration shall be shared equally between the Applicant and the Respondent.

EXCLUSIVE JURISDICTION

The Claimant(s) and the Claims Adjudicators agree that the Courts of the Canadian province or territory of residence of the Claimant(s) shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding, law suit or cause of action whatsoever arising from the relationship between the Claimant(s) and Claims Adjudicators. The Claimant(s) and the Claims Adjudicators further agree to undertake to submit to an arbitration process, to the exclusion of the Courts, any present or future dispute relating to a claim. The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the Claimant(s). The Claimant(s) and the Claims Adjudicators agree that any complaint, demand, claim, proceeding, law suit or cause of action will be referred to arbitration and that the costs of any arbitrator and arbitration shall be shared equally between the Applicant and the Respondent.

Signature of Person or Dependent in Hospital ("**Claimant(s)**"):_____

(If applicable) Guardian Signature for **Claimant(s)**_____

Date signed:_____