

Your child critical illness claim



This document outlines the requirements to apply for your individual child critical illness benefits.

Step 1: Claimant's initial statement

- Complete the *Claimant's initial statement* (form **186 CAN**).¹ If additional space is required, write on a separate page.
- The completed claimant's initial statement provides us with notice of your child critical illness claim. It also provides us with general information about the child and the child's health.

Step 2: Physician's initial statement

- Have your child's doctor complete the *Physician's initial statement* (form **70-0734**) located at canadalife.com.²
- To avoid delays with the review of your claim we recommend that you include copies of all relevant medical records with the physician's initial statement, such as chart notes, consultation reports and test results.
- The completed physician's initial statement provides us with information regarding your child's medical condition and treatment plan.
- Your child's doctor can mail, email or fax the completed physician's initial statement directly to The Canada Life Assurance Company (Canada Life) at the contact information below.

Contact information

The Canada Life Assurance Company
Living Benefits Claims
PO Box 6000, Winnipeg MB R3C 3A5

Email: lbclaims@canadalife.com

Fax: 1-204-946-4030

Toll-free: 1-877-280-7527

Visit canadalife.com

Our responsibility

The review of your claim will begin when we receive your *Claimant's initial statement* and *Physician's initial statement*.

Once we receive the claimant's initial statement, we will send you an acknowledgment letter or email which will provide you with your claim specialist's name and contact information. Your claim specialist will contact you within 10 business days from having received the claimant's initial statement to let you know what you can expect throughout the claim process and to obtain any further information that may be required.

Email disclaimer

The protection of confidential client information is very important to our organization. Email, although very convenient, is not a secure medium for the exchange of confidential personal information. We cannot guarantee the security of correspondence via email. If you wish to receive correspondence by email, please note that we can take no responsibility for ensuring that the information will remain confidential and not be intercepted or read by others, either over the internet or through the receiving computer. By giving us your email address in 1.6, you acknowledge and agree that you are aware of the risk and are accepting this risk.

Protecting your personal information

At Canada Life, we recognize and respect the importance of privacy. Personal information about your child is kept in a confidential file at the offices of Canada Life, or the offices of an organization authorized by Canada Life. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life, who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your child's personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, store, use and disclose the personal information to investigate and assess your claims with Canada Life. For a copy of our Privacy Guidelines or if you have any questions about our personal information policies and practices (including with respect to service providers), write to Canada Life Chief Compliance Officer or refer to canadalife.com.

¹ In providing any claim forms, Canada Life does not admit any liability or waive any of its rights.

² You are responsible for any fees related to the completion of the forms and any other medical information provided.



Claimant's initial statement

Child critical illness claim

1. Insured's information

- 1.1 Policy numbers: _____
- 1.2 Name of insured child: _____
- 1.3 Date of birth (day/month/year): _____
- 1.4 Address (street number and name): _____
City: _____ Province: _____ Postal code: _____
- 1.5 Phone number: _____
- 1.6 Email address (optional): _____
See *Email disclaimer*.

2. Claim and related details

- 2.1 Describe the nature and extent of the insured child's critical illness:

- 2.2 On what date did the insured child first consult a medical practitioner in connection with their illness?

Date (day/month/year): _____

Name of medical practitioner: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Phone number: _____

- 2.3 On what date was the insured child's condition diagnosed or surgery performed? (day/month/year) _____

On what date did symptoms commence? (day/month/year) _____

Describe these symptoms: _____

- 2.4 Has the insured child undergone any tests or investigations related to the diagnosis?

Yes, provide details and dates below No

- 2.5 Has the insured child previously suffered from or received treatment for a similar condition?

Yes, provide details and dates below No

3. Medical consultations

3.1 Provide the following information for the insured child's personal physician.

Name: _____ Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Phone number: _____ Date seen (day/month/year): _____

3.2 Provide details of any other doctors or specialists who have been consulted in connection with the insured child's illness.

Name: _____ Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Phone number: _____ Date seen (day/month/year): _____

Name: _____ Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Phone number: _____ Date seen (day/month/year): _____

3.3 Provide the following information if the insured child has been treated at a hospital or similar institution.

Name of hospital: _____ City or town: _____

Date of admission (day/month/year): _____ Date of discharge (day/month/year): _____

Name of hospital: _____ City or town: _____

Date of admission (day/month/year): _____ Date of discharge (day/month/year): _____

3.4 What other treatments has the insured child received and currently receiving in connection with their condition?
(for example, medications, therapy, etc)

Name of institution: _____ Type of treatment: _____

Prescribing physician: _____ Dates (day/month/year): _____

Name of institution: _____ Type of treatment: _____

Prescribing physician: _____ Dates (day/month/year): _____

4. General

4.1 Is the child insured for similar benefits from another company? Yes, provide details below No

Name of insurer: _____ Type of benefits: _____

Amount of benefit: \$ _____ Has a claim been submitted? Yes No

Name of insurer: _____ Type of benefits: _____

Amount of benefit: \$ _____ Has a claim been submitted? Yes No

Name of insurer: _____ Type of benefits: _____

Amount of benefit: \$ _____ Has a claim been submitted? Yes No

Name of insurer: _____ Type of benefits: _____

Amount of benefit: \$ _____ Has a claim been submitted? Yes No

If you answered yes to a claim being submitted, provide the following information.

Name of claims specialist: _____

Phone number: _____

4.2 Provide any further information which you think might be helpful in support of the insured child's claim.

5. Your consent

Before we can process your claim for benefits, you must read this agreement and provide a handwritten signature in the box below.

Sharing your personal information

We collect, use and disclose your personal information to:

- Investigate and assess your claim
- Administer your claim
- Audit the assessment of the claim

We may collect and exchange personal information with these persons or groups when relevant and necessary for the purpose above:

- Healthcare and rehabilitation providers
- Independent medical specialist
- Insurance and reinsurance companies
- Administrators of government benefits and of other benefit programs
- Any person having knowledge of the child and their health
- Other organizations or service providers working with us
- **Optional:** Insurance advisor associated with this policy. If you agree, please provide the advisor's name and contact information.

Name of advisor: _____

Phone number or email address: _____

Do you wish for Canada Life to deliver any benefit cheque payable in connection with this claim to your insurance advisor so they can deliver the cheque to you?

Yes No, send cheque directly to me

Protecting your privacy

We take your privacy seriously. We keep all personal information in a confidential file in our offices, or the offices of an organization we've authorized. This information may include medical and psychiatric information. Canada Life may use service providers located within or outside Canada. The only persons with access to the information are:

- People working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim
- Those whom you've given access
- Those authorized by law both within Canada and in any other jurisdiction where personal information is held

By signing below, you confirm that:

- You have read, understand, and agree with the contents of this form and authorize us to collect and disclose personal information.
- Subject to legal and contractual restrictions, your authorization is valid for the duration of your claim or until you cancel it in writing.
- All statements you have made about your claim are true and complete.
- A photocopy or electronic copy of this authorization is as valid as the original.

Date signed (day/month/year): _____

Name of insured child: _____

Name of parent or guardian: _____

Parent or guardian phone number: _____

Your policy numbers: _____

X

Signature of **insured child**, if over 18 years

X

Signature of **parent or guardian**, if the insured child is under 18 years