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YOUR CRITICAL ILLNESS CLAIM

This document contains the two forms you need to apply for critical illness benefits under your individual policy and information about the claims process.

- ➢ Step 1 - In order to avoid any delays, please complete Part I “Claimant’s Initial Statement” in its entirety.
- ➢ Step 2 - Have your treating physician or specialist complete Part II “Attending Physician’s Initial Statement”.
- ➢ Step 3 - Once both forms are completed, send your original claim form to the Canada Life Office at the following address:

  Living Benefits Claims Department
  PO Box 6000
  Winnipeg MB R3C 3A5

  Note: In furnishing any claim forms, the company does not admit any liability or waive any of its rights. It is your responsibility to have all medical forms completed without cost to Canada Life.

- ➢ Step 4 - Once we receive your forms we will send you an acknowledgement letter which will provide you with your Claims Specialist’s name and contact information.
- ➢ Step 5 - Your Claims Specialist will then begin the process of reviewing your claim and will notify you of the outcome of our review.

HOW TO GET IN TOUCH

- Toll free 1.877.280.7527, ext. 8577#
- Fax No. 204.946.4030
- E-mail address cllbclaims@canadalife.com

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 on page 2, 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 you 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 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 claim(s) 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 www.canadalife.com.

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PART I:
CLAIMANT'S INITIAL STATEMENT
CRITICAL ILLNESS CLAIM

LIVING BENEFITS CLAIMS
PO BOX 6000
WINNIPEG MB R3C 3A5
FAX 204.946.4030

IDENTIFICATION AND CONTACT INFORMATION

Claimant's name	Home phone number (______) _____ - ______________	Policy number(s)
Date of birth Month __________ Day __________ Year __________	Cellular phone number (______) _____ - ______________	
Home address City Province	Postal Code	Email address (optional) **(Please see Email Disclaimer on page 1)**

CLAIM DETAILS

1. Nature of critical illness (diagnosis): ______________________________
2. Date symptoms began: ______________________________ (dd/mm/yy)
3. Date of first medical consultation: ______________________________ (dd/mm/yy)
4. Date of diagnosis: ______________________________ (dd/mm/yy)
5. Date of surgery, if applicable: ______________________________ (dd/mm/yy)
6. Were you hospitalized? ☐ Yes ☐ No If so, what hospital? ______________________________
   From: ______________ To: ______________ (dd/mm/yy)
7. Have you had the same or similar condition in the past? ☐ Yes ☐ No
   If yes, please provide details of dates and physicians consulted:
   ____
   ____
   ____
8. Have any of your parents or siblings suffered from a similar or related illness? ☐ Yes ☐ No
   If yes, state relationship, nature of illness and the age at which the illness was diagnosed:
   ____
   ____
   ____

MEDICAL CONSULTATIONS

Physician's name, address, and specialty:	Date first consulted (dd/mm/yy)
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

OTHER INSURANCE

Please indicate if you have other critical illness coverage. (Whether or not your claim has been approved.)

Name of insurer: ______________________________

Policy number: ______________ Benefit amount: ______________ Date of issue: ______________ (dd/mm/yy)

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CLAIMANT'S CHECKLIST

- ☐ Is the Claimant's Initial Statement complete?
- ☐ Has the Attending Physician's Initial Statement been completed and signed by your attending physician?
- ☐ Have you attached copies of all the required medical evidence as requested on the Physician's Initial Statement?

AUTHORIZATION AND DECLARATION

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Canada Life, any healthcare or rehabilitation provider, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Canada Life, or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s). This may include performing independent assessments.

I acknowledge that the personal information is needed to investigate and assess my claim(s). I acknowledge that my consent enables Canada Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written notice.

This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) are true and complete. I agree that all such statements form the basis for any benefit approved.

Print Claimant Name	Claimant Signature	Date (dd/mm/yy)

I authorize and direct The Canada Life Assurance Company to deliver any benefit cheque payable in connection with this claim to my insurance advisor associated with this policy for deliver to me.

Print Advisor Name	Advisor Telephone Number

Signature of Claimant	Date

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PART II:
ATTENDING PHYSICIAN'S INITIAL STATEMENT
CRITICAL ILLNESS CLAIM

LIVING BENEFITS CLAIMS
PO BOX 6000
WINNIPEG MB R3C 3A5
FAX 204.946.4030

PATIENT INFORMATION

Name (please print)	Policy number	Date of birth Month _________ Day _________ Year _______
Address		Telephone number (including area code)

MEDICAL CONDITION

1. What is the diagnosis? ______________________________

2. What is the date of the diagnosis? ______________________ (dd/mm/yy)

3. **EVIDENCE REQUIRED:**
In order to consider this claim, please provide copies of all medical evidence regarding the investigation, diagnosis and treatment of this condition including test results, laboratory results, surgical reports and consultation reports.
Example:
i) Cancer: provide initial consultation report, pathology report, and oncology report.
ii) Heart Attack: provide all ECG reports, laboratory results, angiography/cath lab reports, and clinical chart notes.

HISTORY OF CONDITION

1. How long has this person been your patient? ______________________________

2. Was the patient referred to you? ☐ Yes ☐ No
If yes, by whom? ______________________________

3. On what date did your patient first have symptoms? ______________________ (dd/mm/yy)

4. On what date did your patient first consult you for this condition? ______________________ (dd/mm/yy)

5. Has your patient previously suffered from the condition specified above or any related condition? ☐ Yes ☐ No
If yes, please provide the dates and additional details.

6. Any relevant family history?

7. Smoking history?

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TREATMENT

1. Please provide names and addresses of other physicians consulted or hospitals attended by your patient for this condition.

Name of Physician or Hospital	Address (number, street, city, province, postal code)	Date from (dd/mm/yy)	Date to (dd/mm/yy)

2. Please provide any other information that would be helpful in the assessment of your patient's claim.

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SIGNATURE (please print or use a stamp)

Last name	First name	Specialty
Address		Telephone number
City	Province	Fax number
Postal code	Signature	Date Month ________ Day ________ Year ________

PLEASE BE ADVISED THAT YOUR PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES INCURRED FOR ITS COMPLETION.