canada life™

Instructions:
*1. Please **PRINT**.*
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

Critical Illness Insurance - Confidential Physician's Report
Benign Brain Tumor

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL**

Part 1: Patient Authorization

Name *(please print)*	Policy No.
	Date of Birth *(day, month, year)*
Address *(number, street, city, province, postal code)*	Telephone no. *(including are code)* ( ) –

I hereby authorize the release to my insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim.

Patient's signature | Date *(day, month, year)*

Part 2: Physician's Report

1. a) On what date did your patient first have symptoms? What were they?

   Date *(day, month, year)* _____

   _____

   b) If applicable, please describe any objective neurological deficits your patient had. Please check if none. ☐

   _____

   _____

   c) When did your patient first consult you for this condition? Date *(day, month, year)* _____

   d) How long has this person been your patient? _____

2. Please provide the date this benign brain tumor was diagnosed. Date *(day, month, year)* _____

3. Please provide a copy of the pathology report giving the following details:

   a) If available, please provide a copy of the following reports: CT, MRI, Surgical and Pathology indicating:
   - Type of Tumor
   - Site of Tumor
   - Histology

   b) Please provide the date of surgery if applicable. ☐ Yes Date *(day, month, year)* _____ ☐ No

   c) Please provide the date of radiation if applicable. ☐ Yes Date *(day, month, year)* _____ ☐ No

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this Tumor:

Name of Physician or Hospital	**Address** *(number, street, city, province, postal code)*	**Date from** *(day, month, year)*	**Date to** *(day, month, year)*

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

Please provide copies of any specialist or hospital reports.

Name of attending physician *(please print)*	Specialty	Telephone no. *(including area code)* ( ) —
Address *(number, street, city, province, postal code)*		
Signature		Date *(day, month, year)*

Submit to: **The Canada Life Assurance Company**
Critical Illness Claims Unit, S3
330 University Avenue
Toronto ON M5G 1R8
Toll Free 1.866.907.2395
Fax 416.552.6557

Authorizations and Declarations

I have read and understand and agree with the contents of the section entitled “Protecting Your Personal Information”

I authorize:

- Canada Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Print name _____ Signature _____

Date _____ Phone number _____

Notice About Medical Information Bureau

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to the MIB Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance or submit a claim for benefits to such a company, the bureau will upon request supply the company with the information it may have.

Canada Life or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the bureau the action taken on the basis of your current request for insurance.

If you wish to see the information in your bureau file or have it corrected, please contact the bureau’s information office at:

MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Tel 781-751-6000

Protecting Your Personal Information

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life.

Who has access to your information:

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 and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life’s and its affiliates’ internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship. The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life’s Chief Compliance Officer or refer to www.canadalife.com.

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