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
Blindness

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 area 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) When did your patient first consult you for any eye problems?

   Date *(day, month, year)* _____

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

2. On what date did your patient first suffer symptoms or become aware of any eye problem? Please provide details.

   Date *(day, month, year)* _____

   _____

3. a) What is the corrected vision or field of vision in each eye?

   _____

   b) On what date was this test performed? Date (day, month, year) _____

   c) Please provide the name and address of the opthalmologist.

Name of opthalmologist	**Address** *(number, street, city, province, postal code)*	**Telephone no.** *(including area code)*
		( ) —

   d) What is the cause of the blindness?

   _____

   _____

   e) Is the blindness permanent? ☐ Yes ☐ No

   f) Is there any treatment that could improve your patient's vision?

   _____

4. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this vision loss or any related disorder:

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 report.

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

AUTHORIZATION 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.

Patient Signature _____ Date Signed _____

Protecting Your Personal Information

At **The Canada Life Assurance Company,** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file 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. Canada Life may use service providers located within or outside Canada. 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. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. 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.

NOTICE ABOUT MIB INC.

Important Notice

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:

Suite 501
330 University Avenue
Toronto ON M5G 1R7
Tel 416.597.0590

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