

Physician's initial statement

Group Critical Illness claim

1. Patient information

- 1.1** Policy numbers: _____ **1.2** Certificate/ID number: _____
- 1.3** Name of insured: First name: _____ Last name: _____
- 1.4** Date of birth (dd/mm/yy): _____
- 1.5** Address (street number and name): _____
City: _____ Province: _____ Postal code: _____
- 1.6** Insured's phone number: _____
- 1.7** Insured's email address: _____

2. Medical condition

- 2.1** Indicate the diagnosis: _____
- 2.2** Date of diagnosis (dd/mm/yy): _____

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:

- Cancer: provide initial consultation report, pathology report and oncology report.
- Heart attack: provide all ECG reports, laboratory results, angiography or cath lab reports and clinical chart notes.

3. History of condition

- 3.1** How long has this person been your patient? _____
- 3.2** Was your patient referred to you? ☐ Yes ☐ No

If yes, provide the name and address of the family doctor and referring physician:

Family doctor's name: _____
Address (street number and name): _____
City: _____ Province: _____ Postal code: _____
From (dd/mm/yy): _____ To (dd/mm/yy): _____

Referring physician's name: _____
Address (street number and name): _____
City: _____ Province: _____ Postal code: _____
From (dd/mm/yy): _____ To (dd/mm/yy): _____

- 3.3** On what date did your patient first have symptoms? (dd/mm/yy): _____
- 3.4** On what date did your patient first consult you for this condition? (dd/mm/yy): _____
- 3.5** Has your patient previously suffered from the condition specified above or any related condition? ☐ Yes ☐ No
If yes, provide the name of the referring physician:
First name: _____ Last name: _____
- 3.6** Relevant family history: _____
- 3.7** Smoking history: _____

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4. Treatment

4.1 Provide the names and addresses of other physicians consulted or hospitals attended by your patient for this condition.

Name of physician or hospital: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

From (dd/mm/yy): _____ To (dd/mm/yy): _____

Name of physician or hospital: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

From (dd/mm/yy): _____ To (dd/mm/yy): _____

Name of physician or hospital: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

From (dd/mm/yy): _____ To (dd/mm/yy): _____

4.2 Provide any other information that would be helpful in the assessment of your patient's claim.

5. Physician information and signature

5.1 Name of physician: _____

5.2 Specialty: _____

5.3 Phone number: _____ Fax number: _____

5.4 Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Signature of physician X _____ **Date signed (dd/mm/yy):** _____

- The patient is responsible for any fees related to the completion of this form and any other medical information provided.
- Mail, email or fax to:

The Canada Life Assurance Company
Critical Illness Claims Unit, S8
330 University Avenue
Toronto ON M5G 1R8

Toll free: 1-866-907-2395

Fax: 416-552-6557

Email: GroupCIClaims@canadalife.com

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Notice about MIB, LLC.

Important Notice

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to MIB, LLC., 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, LLC. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Tel 781-751-6000

Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your [online account](#) or by submitting a request through our [privacy centre](#) at [canadalife.com/privacy](#). This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information. If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit [canadalife.com/privacy](#).

Privacy consent, authorizations and declarations

I understand that my personal information will be collected, used and shared as set out above.

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 Privacy consent, 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.

Signature of patient X _____ **Date signed (dd/mm/yy):** _____

Clear