

INSTRUCTIONS:

1. Plan member completes sections 1, 2, and 4. Physician completes section 5.
2. Complete the form in full to avoid delays in assessment. Physician's fees for providing medical information are not covered under your plan.
3. Sign and date the form.
4. Retain a copy of this form for your records.

Please send to: Medical and Dental Claims Management
The Canada Life Assurance Company
PO Box 6000
Winnipeg MB R3C 3A5
Fax: 204-938-2820
Email: medicalsolutions@canadalife.com
Website: canadalife.com

Questions? Call Toll Free: 1-800-957-9777 Or
Refer to your Canada Life Employee Benefits Booklet
Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us: TTY to Voice: 711
Voice to TTY: 1-800-855-0511

As email is not a secure medium, any person with concerns about their medical information being intercepted by an unauthorized party is encouraged to submit their forms by other means.

Section 1 – Plan member information

Plan number		Plan member I.D. number	
Plan member name			
Last name		First name	
Plan member address			
Number and street		City or town	Province
			Postal code
Date of birth			
Day	Month	Year	

Section 2 – Dependant information

Last name		First name	
Relationship to plan member	Date of birth	Day	Month
		Year	Marital status
			☐ Single ☐ Married/common-law ☐ Other _____
Residence of dependant (if different from plan member)			
Number and street		City or town	Province
			Postal code

If the dependant is not a resident of your home 365 days a year, please explain.

Dependant's education

Highest level of education attained: _____ Is the dependant currently attending an educational facility? ☐ Yes ☐ No

If "Yes": Is the dependant attending full time? ☐ Yes ☐ No Anticipated program completion date: Day _____ Month _____ Year _____

Name of program and facility _____

If "No": Name of last program and facility attended, last day of attendance and reason for end of attendance.

Dependant's employment

Has the dependant ever been employed? ☐ Yes ☐ No If "Yes" please provide the most recent date(s) and type(s) of employment.

Period of employment (dd/mm/yy) to (dd/mm/yy)	Employer	Job title	Average monthly income	Hours worked per week

Reason for leaving employment: _____

Section 2 – Dependant information, *continued***Other Coverage with Canada Life**

Has the dependant ever been covered as a dependant with a disability under any other Canada Life plan? ☐ Yes ☐ No

If yes, please provide the plan and ID numbers: Plan number: _____ ID number: _____

Additional documents

Please attach any available supporting documents. Examples include:

- Recent educational assessments
- Recent cognitive assessments or neuropsychological reports
- Clinical notes or specialist reports issued in the past year
- Approval letter from a provincial disability program

Please indicate whether your dependant requires assistance managing any of the following, and if so, describe supports needed.

Personal care/hygiene (bathing, dressing, toileting, etc.)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Treatment (taking medications, attending appts, etc.)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Personal finances (banking, paying bills, budgeting, etc.)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Home care (cooking, cleaning, grocery shopping, etc.)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Transportation (driving, taking bus, etc.)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Routine/schedule (creating and adhering to a schedule)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Decision making (using judgement to make good decisions)	☐ Yes ☐ No	If Yes, describe the support needed. _____
Planning (ability to plan for the future)	☐ Yes ☐ No	If Yes, describe the support needed. _____

Section 3 – Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either 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](#).

Section 4 – Privacy consent, authorization and signature

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

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants; and that my spouse and/or dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offense. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

I agree that by submitting this form or authorizing it to be submitted, I am consenting to the terms set out in this section, even if I have not signed the form.

Plan member's signature X _____

Date

Day

Month

Year

Section 5 – Attending physician's statement

Primary diagnosis: _____ Date of diagnosis: (dd/mm/yy) _____

Secondary diagnosis: _____ Date of diagnosis: (dd/mm/yy) _____

Secondary diagnosis: _____ Date of diagnosis: (dd/mm/yy) _____

Functional Abilities

Does the patient have impairments in PHYSICAL functioning? ☐ Yes ☐ No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A

If the impairments are not permanent, when are they expected to resolve or improve? _____

Does the patient have impairments in COGNITIVE functioning? ☐ Yes ☐ No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A

If the impairments are not permanent, when are they expected to resolve or improve? _____

Please describe the nature and severity of any cognitive impairments.

Does the patient have impairments in any of the following areas?

Sitting	☐ Yes ☐ No	Details: _____
Ambulation	☐ Yes ☐ No	Details: _____
Lifting/carrying	☐ Yes ☐ No	Details: _____
Manual dexterity	☐ Yes ☐ No	Details: _____
Speech	☐ Yes ☐ No	Details: _____
Hearing	☐ Yes ☐ No	Details: _____
Vision	☐ Yes ☐ No	Details: _____

Please describe the type of work the patient can perform.

Treatment (include medications, therapies, and other treatments)

Date of last appointment (dd/mm/yy) _____ Date of next appointment (dd/mm/yy) _____

Describe the current treatment plan (use a separate page if necessary).

List any other physicians / care providers involved in the patient's treatment (use a separate page if necessary).

Name	Specialty	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 5 – Attending physician's statement, *continued*

Prognosis: _____

Please provide any other comments you feel would assist us in understanding the patient's situation.

I declare that the information in this section is true to the best of my knowledge.

Physician's name

Name _____

Specialty _____ Telephone number _____ Fax number _____

Physician's address

Number and street _____ City or town _____ Province _____ Postal code _____

Physician's signature X _____ **Date** Day _____ Month _____ Year _____

Clear