GROUP PORTABLE CRITICAL ILLNESS CLAIMANT'S STATEMENT

Please print in ink and fully complete the form.

Claimant name	Policy number **177914**	Member certificate number

Address *(number, street, city, province, postal code)*

Date of birth *(dd/mm/yyyy)*	Gender ☐ Male ☐ Undisclosed ☐ Female ☐ Other	Phone number *(including area code)* ( ) —

Claim and Related Details

1. Please describe the nature and extent of your critical illness:

   On what date was your condition diagnosed or surgery performed? Date *(dd/mm/yyyy)* _____

2. On what date did symptoms start? Date *(dd/mm/yyyy)* _____

   Please describe these symptoms:

3. On what date did you first consult a medical practitioner in connection with your illness? Date *(dd/mm/yyyy)* _____

   Please indicate the name and address of the physician seen:

   Name

   Phone number *(including area code)*

   ( ) —

   Address *(number, street, city, province, postal code)*

4. Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates:

5. Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No

   If yes, please give details, including dates:

Medical Consultations

1. Please provide the name and address of your personal physician:

Name

Phone number *(including area code)*

( ) –

Address *(number, street, city, province, postal code)*

2. Please provide details of any physicians who have been consulted in connection with your illness:

Name	**Address** *(number, street, city, province, postal code)*	**Phone number** *(including area code)*	**Dates seen** *(dd/mm/yyyy)*
		( ) –	
		( ) –	
		( ) –	

3. If you have been treated at a hospital or similar institution, please supply the following information:

Name of hospital	**City or town**	**Date of admission** *(dd/mm/yyyy)*	**Date of discharge** *(dd/mm/yyyy)*

4. What other treatment have you received and are you currently receiving for your condition? (e.g., medications, therapy)

Type of treatment	**Institution**	**Prescribing physician**	**Dates** *(dd/mm/yyyy)*

General

1. Has any blood relative suffered from a similar or related condition? ☐ Yes ☐ No If yes, please indicate:

Relationship	**Nature of illness**	**Age at which illness was first diagnosed**

2. Are you insured for benefits related to this condition from another company? ☐ Yes ☐ No If yes, please indicate:

Name of insurer	**Type of benefit**	**Amount of benefit insured**	**Has a claim been submitted?**
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

3. Do you smoke or use tobacco products?

☐ Yes If yes, please indicate amount per day: _____ How long have you used tobacco? _____

☐ No If no, did you previously use tobacco products? ☐ Yes ☐ No

On what date did you quit? *(dd/mm/yyyy)* _____

4. Please provide any further information that might be helpful in support of your claim:

Authorizations and Declarations

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Canada Life to exchange personal information, when necessary for the purpose of assessing my claim, and administering the group benefits plan;
- Canada Life to release information about my claim to an auditor authorized by my employer, plan sponsor or their agent and Canada Life at any time for the purpose of auditing the assessment of the claims;
- Canada Life to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan.

Except for audit purposes, this authorization shall remain valid for the duration of my claim 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 claim form and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as a result of a claim.

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.

Please return the completed form and supporting documents to:

The Canada Life Assurance Company
Critical Illness Unit
330 University Ave.
Toronto ON M5G 1R8

Toll Free: 1.866.907.2395
Fax: 416.552.6557

Email: GroupCIClaims@canadalife.com

Email Communication – Important Note:
The internet is not a secure medium. If you have concerns about using email, you are encouraged to contact us by other means.

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