Freedom to Choose™ accident insurance Privacy disclosure

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.

Freedom to Choose™ Accidental Dismemberment or Specific Loss Claim

Part 1 Statement

Name of Claimant: _____ ☐ Member ☐ Spouse ☐ Child

Group Policy No.: 177914 Certificate No.: _____

Address: _____

Claimant Phone No.: _____ Date of Birth (dd/mm/yyyy): _____

Total amount of insurance coverage: $ _____

Amount of Accidental Dismemberment or Loss Benefit: $ _____

In what capacity or by what title do you claim this insurance money? _____

Are you over the age of 18? ☐ Yes ☐ No If not, what is your date of birth? _____

Are you legally entitled to receive the whole of the monies payable under this policy, and to give the company a valid discharge therefor? _____

Please advise how you wish to receive these proceeds:

☐ Cheque
☐ EFT (Electronic Fund Transfer to Canadian bank account - please attach a personalized void cheque or an electronic bank form)
☐ Please arrange for a financial advisor to visit and discuss my options. The best time to call me is _____

PLEASE NOTE ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

Part 2 Accident details

Date of Accident: _____ Did the accident take place in the course of employment?* ☐ Yes ☐ No

Briefly describe how the accident occurred:

_____

_____

_____

_____

Name of hospital if you were confined: _____

Dates of hospitalization: _____

Name of Attending Physician: _____

Physician's Address: _____
STREET CITY PROVINCE POSTAL CODE

Date of first treatment: _____

* If yes, please provide your accident report.

Authorizations and declarations

I have read and understand and agree with the contents of the section entitled "Privacy disclosure" on this form.

I authorize Canada Life, any healthcare provider, the plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life or working with the deceased's plan administrator, within or outside Canada, to exchange personal information, when necessary to investigate and assess my claim, to administer the group benefits plan and to audit the assessment of the claim. I further authorize the use of my social insurance number for income tax reporting. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I have provided the information on this form in order to obtain payment of Freedom to Choose™ Accident proceeds payable to me (in a personal capacity or on behalf of a beneficiary) and I hereby declare that I am legally entitled to receive all or a share of the proceeds payable under the Freedom to Choose™ Accident Policy. I certify that by making payment to me, Canada Life has met its obligation to me. By signing below, I confirm that: I have read, understand and agree with the contents of this form and authorize Canada Life to collect, use, and disclose my personal information, all statements I have made about my claim are true and complete, my authorization is valid until I cancel it in writing, and a photocopy or electronic copy of this authorization is as valid as the original.

Print Name _____ Signature _____

Date _____ Social Insurance Number _____

Instructions

1. **ATTACH INSURED'S BENEFICIARY DESIGNATION FORM, IF YOU HAVE THIS RECORD.**
2. **ATTACH CERTIFICATE OF ATTENDING PHYSICIAN (FORMS ATTACHED TO THIS CLAIM FORM)**
3. **ATTACH ACCIDENT REPORT (IE. POLICE REPORT, EMPLOYER'S ACCIDENT REPORT).**

Please return the fully completed form and supporting documents to:

The Canada Life Assurance Company
Group Life Benefits
60 Osborne St N
Winnipeg MB R3C 1V3

OR

Email: grouplifebenefits@canadalife.com
Fax: 204-946-8783

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.

canada life™

Freedom To Choose™ Accident or Loss
Certificate of Attending Physician

Patient's Name: _____

Patient's Address: _____

Group Policy Number: 177914 Group Plan Name: Canada Life Insurance Company of Canada

1. (a) When did the accident happen? Month _____ Day _____ Year _____

   (b) Briefly describe details of the accident. _____

2. (a) Date of first attendance for present injury. Month _____ Day _____ Year _____

   (b) Date of most recent treatment. Month _____ Day _____ Year _____

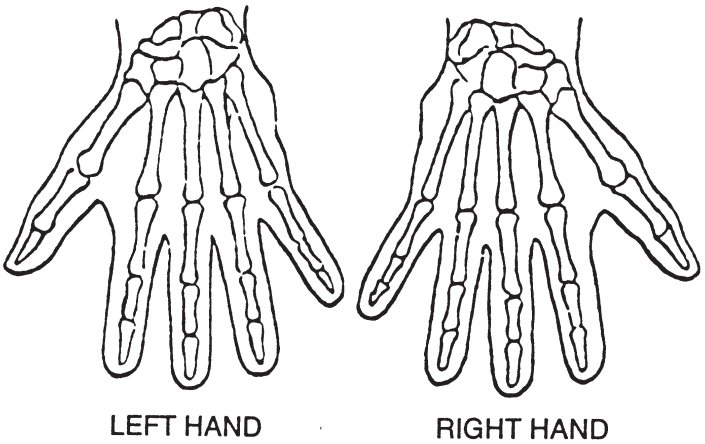
DISMEMBERMENT

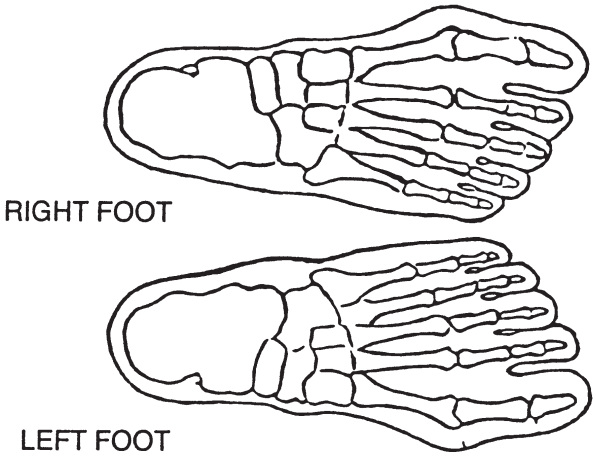
3. (a) If the accident caused the loss of hand, foot, leg, arm, fingers, toes, please indicate the specific joint level of the amputation on the diagram below.

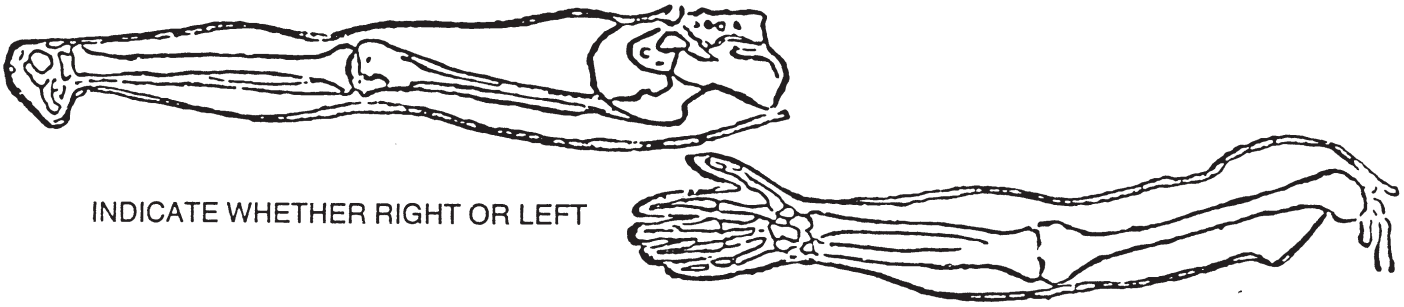
   ☐ Hand ☐ Foot ☐ Leg ☐ Arm ☐ Fingers ☐ Toes

   (b) Date of amputation. Month _____ Day _____ Year _____

   (c) Please include surgery report and hospital admittance and discharge summary.







4. (a) If the accident caused total and irrecoverable loss of sight, hearing or speech, please indicate which:

☐ Sight ☐ Hearing ☐ Speech

(b) Date on which loss occured. Month _____ Day _____ Year _____

(c) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

LOSS OF VISION

(a) If known to you, please advise the vision in each eye prior to the accident.

(b) What is the best corrected vision in the affected eye(s), if any?

(c) Please include visual acuity results and Opthalmologist report.

LOSS OF HEARING

(a) Is there any indication that hearing was abnormal prior to accident?

(b) Level of hearing at date of loss.

(c) Please include Audiologist report and hearing test.

LOSS OF SPEECH

(a) If known to you please advise if the insured was able to speak intelligibly prior to accident.

(b) Is insured's speech intelligible at the present time?

(c) Please include Speech Therapy assessment.

LOSS OF USE

5. (a) If the accident caused loss of use of leg, arm, or hand, please advise which.

☐ Leg ☐ Arm ☐ Hand

(b) Is there any indication that the injured limb was unable to function normally prior to accident? ☐ Yes ☐ No

(c) Please indicate what functions, if any, the injured limb is able to perform.

(d) Is there any possibility of improvement to the injured area? ☐ Yes ☐ No

(e) Please include: Hospital admittance and discharge summary, surgery report (if relevant), Range of Motion test results and Physiotherapist / Occupational Therapist reports, consultation and progress reports, Neurologic exam (paraplegia / quadriplegia).

6. (a) Was the injury described solely responsible for the loss? ☐ Yes ☐ No

(b) If not, give particulars of any contributing cause or causes.

Print Name _____ Specialty _____ Telephone Number: _____

Date _____ Signed _____ M.D.

Address _____
Street City Province Postal Code

Clear