YOUR CHILD CRITICAL ILLNESS CLAIM

We are pleased to provide you with a claim form for your use when claiming for benefits provided under your Child Critical Illness policy.

We understand that this may be a difficult time for you, and we want to assure you that your claim is important to us at Canada Life. We would like to provide you with some information that will help you to understand what we need from you in order to process your claim.

NOTIFICATION OF CLAIM

You must notify Canada Life about the child's condition within 30 days of the date of the diagnosis of a condition covered by the policy. You can notify us by sending us a letter by mail or fax, or by calling our office. You'll find our contact information on the next page.

THE CLAIM FORM

Once you have notified us of the claim, the next and perhaps the most important step for you is to send us fully completed claim forms. You must complete the Claimant's Statement portion of the claim form. The physician who was first consulted for your child's condition must complete the Physician's Report.

Both forms must be completed and sent to Canada Life. Although the forms may be submitted separately, we will require both forms in order to adjudicate the claim. It is your responsibility to have the medical forms completed without expense to Canada Life. Please have the completed forms sent to us at the address on the next page. Please detach and keep this information sheet. In addition, you may find it helpful to keep a photocopy of the completed forms. If you have any questions while you are completing the form, you can reach us at the numbers shown on the next page.

OUR FIRST CONTACT

Once we have received your completed claim form, we will assign the claim to a claims specialist for review. Your claims specialist will send you a letter to acknowledge the receipt of the form and to provide you with their name and telephone number in case you have any questions about the claim.

REQUEST FOR MEDICAL INFORMATION

When necessary, the claims specialist will write directly to the physician or hospital to obtain required information. If we do not get a response within approximately one month of the request, we will send a follow-up letter to the physician or hospital. At the same time, we will notify you of the status of your claim.

You are responsible for providing medical proof that you are entitled to receive critical illness benefits. Your doctor may charge a fee for supplying this information and you would be responsible for paying that fee. When Canada Life requests information directly from your doctor, we will offer to pay a correspondence fee towards the cost of the information.

INITIAL DECISION

We will make an initial decision on the claim within 30 days of our receipt of satisfactory medical evidence. We will make one of the following decisions:

1. Approve the claim if the evidence we have received supports the definition of a condition covered by the policy.
2. Decline the claim if one or more terms of the policy have not been met. Your claims specialist will send you a letter explaining our decision, and what further information we would need to reconsider the decision.

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HOW TO GET IN TOUCH

If you have any questions about the claim, please contact your claims specialist by telephone, fax or mail.

Canada Life Assurance Company
Living Benefits Claims Department
PO Box 6000
Winnipeg, MB R3C 3A5
Toll free 1.877.280.7527, ext. 8577#
Fax 204.946.4030
Email address cllbclaims@canadalife.com

PROTECTING YOUR PERSONAL INFORMATION

At Canada Life, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains personal information about both you and the child. This file is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. 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. We collect, use and disclose the personal information to process this application and, if this application is approved, to provide and service the financial product(s) applied for, advise you of products and services to help you plan for your financial security, investigate and process claims, and create and maintain records concerning our relationship.

Child Critical Illness Insurance
Proof of Claim - Claimant's Statement

The Canada Life Assurance Company
Living Benefits Claims Department
PO Box 6000
Winnipeg MB R3C 3A5
Phone No. 204.946.8577
FAX No. 204.946.4030

Instructions:
1. Please **PRINT** in ink.
2. Incomplete forms will be returned.

Part 1: Insured's Information

Name of insured	Date of Birth (day, month, year)	Policy No.

Address (number, street, city, province, postal code)	Phone No. (including area code)

Part 2: Claim and Related Details

a) Please describe the nature and extent of the Insured Child's Critical Illness:

b) On what date did the Insured Child first consult a medical practitioner in connection with their illness? Date (day, month, year) _____

Name	**Address** (number, street, city, province, postal code)	**Telephone No.** (including area code)

c) On what date was the Insured Child's condition diagnosed or surgery performed? Date *(day, month, year)* _____

On what date did symptoms commence? Date (day, month, year) _____

Please describe these symptoms:

d) Has the Insured Child undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates.

e) Has the Insured Child previously suffered from or received treatment for a similar condition? ☐ Yes ☐ No

If yes, please give details including dates. _____

Part 3: Medical Consultations

a) Please provide the Name and Address of the Insured Child's personal physician.

Name	**Address** (number, street, city, province, postal code)	**Telephone No.** (including area code)	**Date seen** (day, month, year)

b) Please provide details of any other doctors or specialists who have been consulted in connection with the Insured Child's illness:

Name	**Address** (number, street, city, province, postal code)	**Telephone No.** (including area code)	**Date seen** (day, month, year)

c) If the Insured Child has been treated at a hospital or similar institution, please supply the following information:

Name of Hospital	**City or Town**	**Date of Admission** (day, month, year)	**Date of Discharge** (day, month, year)

d) What other treatments has the Insured Child received and are they currently receiving in connection with their condition? (e.g. medications, therapy, etc.)

Type of Treatment	**Institution**	**Prescribing Physician**	**Dates** (day, month, year)

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Part 4: General

a) Is the Insured Child insured for similar benefits from another company? ☐ Yes ☐ No If yes, please indicate:

Name of Insurer	Type of Benefits	Amount of Benefit Insured	Has a claim been submitted?
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

If yes, please provide the name and phone number of the claims specialist: _____

b) Please provide any further information which you think might be helpful in support of the Insured Child's claim.

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AUTHORIZATION AND DECLARATIONS

I/WE, THE UNDERSIGNED, HAVE READ, UNDERSTAND AND AGREE WITH THE CONTENTS OF THE SECTION ENTITLED "PROTECTING YOUR PERSONAL INFORMATION".

I/WE AUTHORIZE CANADA LIFE, ANY HEALTHCARE PROVIDER, OTHER INSURANCE COMPANIES, ADMINISTRATORS OF GOVERNMENT BENEFITS, OTHER ORGANIZATIONS, OR BENEFIT SERVICE PROVIDERS WORKING WITH CANADA LIFE TO EXCHANGE PERSONAL INFORMATION, WHEN NECESSARY TO ASSESS THE CLAIM.

THIS AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING BY ME/US, SUBJECT TO LEGAL AND CONTRACTUAL RESTRICTIONS THAT MAY APPLY. I/WE ACKNOWLEDGE THAT I/WE AM/ARE AWARE OF THE REASONS THE INFORMATION COVERED BY MY/OUR CONSENT IS NEEDED, AS WELL AS OF THE BENEFITS AND RISKS OF NOT CONSENTING.

I/WE AGREE THAT A PHOTOCOPY OR ELECTRONIC COPY OF THIS ***AUTHORIZATION AND DECLARATIONS*** SECTION IS AS VALID AS THE ORIGINAL.

I/WE DECLARE THAT THE STATEMENTS PROVIDED IN THE CLAIMANT'S STATEMENT AND ANY STATEMENT PROVIDED IN ANY PERSONAL OR TELEPHONE INTERVIEW CONCERNING THIS CLAIM WILL BE TRUE AND COMPLETE. I/WE AGREE THAT ALL STATEMENTS FORM THE BASIS FOR ANY BENEFIT APPROVED AS A RESULT OF THIS CLAIM.

NAME OF INSURED CHILD

NAME OF PARENT/GUARDIAN

SIGNATURE OF CHILD (IF OVER 18 YEARS)

SIGNATURE OF PARENT/GUARDIAN (IF THE INSURED CHILD IS UNDER THE AGE OF 18)

DATE (DAY, MONTH, YEAR)

TELEPHONE NO. OF PARENT/GUARDIAN (INCLUDING AREA CODE)

I AUTHORIZE AND DIRECT THE CANADA LIFE ASSURANCE COMPANY TO DELIVER ANY BENEFIT CHEQUE PAYABLE IN CONNECTION WITH THIS CLAIM TO MY INSURANCE ADVISOR ASSOCIATED WITH THIS POLICY FOR DELIVERY TO ME.

PRINT ADVISOR'S NAME

ADVISOR'S TELEPHONE NUMBER

DATE

SIGNATURE OF CLAIMANT

Child Critical Illness Insurance - Confidential Physician's Report

Part 1: Patient Information

Name (please print)	Date of Birth (day, month, year)	Policy No.

Address (number, street, city, province, postal code)	Phone No. (including area code)

Authorization

I hereby authorize the release to The Canada Life Assurance Company of any information or records of the insured Child, (name of child) _____ 's health for the purpose of administering a claim under the above noted policy. This authorization shall continue in effect for a period of one year from the date of execution.

The parent/guardian of the insured Child is responsible for the securing of this form and for any charge that may be made for its completion.

Date (day, month, year) _____ Signature of Insured Child (if over the age of 18) _____

Date (day, month, year) _____ Signature of Parent/Guardian (if the insured is under the age of 18) _____

Part 2: Physician's Report

1. Please indicate the diagnosis.

   _____

2. On what date did your patient first have symptoms? Date (day, month, year) _____

   What were they? _____

   _____

3. On what date did the patient first consult you for the above condition? Date (day, month, year) _____

4. Was your patient referred to you? ☐ Yes ☐ No

   If yes, please provide the name of the referring physician. _____

5. Please provide the names and addresses of other physicians consulted, or hospitals attended by your patient for this condition.

Name of Physician of Hospital	**Address** (number, street, city, province, postal code)	**Date from** (day, month, year)	**Date to** (day, month, year)

6. Please provide any other information that would be helpful in the assessment of your patient's claim.

   _____

   _____

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Please provide copies of all reports and test results that are related to the diagnosis mentioned above, such as pathology reports, lab reports, cardiac echo, MRI, etc. This will help expedite the claims process.

Name of attending physician (please print)	Specialty	Telephone no. (including area code)

Address (number, street, city, province, postal code)	Fax no. (including area code)

Signature	Date (day, month, year)

Submit to: **The Canada Life Assurance Company, Living Benefits Claims Department**
PO Box 6000 Winnipeg MB R3C 3A5
Phone: 204.946.8577 • Fax: 204.946.4030

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