# JOB LOSS
# SUPPLEMENTARY FORM

## A. Claim information must be completed in full

Last Name, First Name | Address:

Unique Client ID: | Claimant's Telephone Number: ( ) - | **Email:**

Authorized User:

Have you returned to work since you became unemployed? ☐ Yes ☐ No | If yes, date: (YYYY/MM/DD) | # of hours:

Are you receiving EI benefits? ☐ Yes ☐ No | If no, why?

Are you currently on strike or lock-out? ☐ Yes ☐ No | Are you receiving strike pay benefits? ☐ Yes ☐ No

**If Yes, attach a copy of your benefit cheque.**

## B. SIGNATURE OF AUTHORIZATION TO OBTAIN INFORMATION - TO BE SIGNED BY CLAIMANT

At **The Canada Life Assurance Company (Canada Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file 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. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who requires it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to administer the group benefits plan, including investigating and assessing claims, and creating and maintaining records concerning our relationship. 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 at Chief_Compliance_Officer@canadalife.com or refer to www.canadalife.com.

I authorize Canada Life, my creditor and / or plan sponsor, my employer, any insurance or reinsurance companies, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, and service providers working with Canada Life or the above to exchange personal information, including consultation reports when relevant and necessary for the purpose of administering the group benefits plan including investigating and assessing my claim.

I acknowledge that the personal information is needed by Canada Life to administer the group benefits plan including investigating and assessing my claim. I acknowledge that my consent enables Canada Life to process my claim and that refusing to consent may result in delay or denial of my claim.

This consent may be revoked by me at any time by sending a written instruction. I agree that a photocopy of this authorization is as valid as the original.

**Which of the following applies to you?**

☐ 1. EI benefit stub is attached.

☐ 2. My EI benefit has not yet commenced due to the severance package I received.
Date severance will end: _____ (YYYY/MM/DD)

☐ 3. I have submitted my verification from my local union concerning a strike or lock-out.

**FORM MUST BE SIGNED AND DATED**

Claimant's Signature: | Date: (YYYY/MM/DD)

PLEASE SUBMIT COMPLETED CLAIM FORM TO:

**The Canada Life Assurance Company**
**Creditor Insurance - Claims Department**

Mail to: 330 University Ave, Toronto ON, M5G 1R8
Or Fax #: 416.552.6557
Or Email to: Western and Northern Provinces: vancouver_creditor@canadalife.com
Ontario : tor_creditor_claims@canadalife.com
Quebec : creances.montreal@canadalife.com
Maritime Provinces: halifaxcreditor@canadalife.com





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