SUPPLEMENTARY DISABILITY CLAIM FORM

CLAIMANT'S STATEMENT:

First Name: ______________________ Last Name: ______________________

Unique Client ID: ______________________ Authorized User: ______________________

Mailing Address:

Street and Number: ______________________

City/Town: ______________ Province: ______________ Postal Code: ______________

Telephone No(s): (_____) _____ - __________ (_____) _____ - __________

Have you returned to work? ☐ Yes, state date you returned to work: ______________ (MM/DD/YY)

☐ No, state date you expect to return to work: ______________ (MM/DD/YY)

SIGNATURE OF AUTHORIZATION TO OBTAIN INFORMATION - TO BE SIGNED BY INSURED:

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.

Signature of Claimant: ______________________ Date: ______________ (MM/DD/YY)

ATTENDING PHYSICIAN'S STATEMENT:

TO BE COMPLETED BY THE ATTENDING PHYSICIAN (ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT)

Diagnosis of Present Condition: ______________________

To the best of your knowledge, is the patient unable to work at their occupation?

☐ Yes, give approximate date when patient should be able to return to work: ______________ (MM/DD/YY)

or estimated number of weeks before possible return: ______________

☐ No, give date patient could have returned to work: ______________ (MM/DD/YY)

Remarks - Please provide comments and further details which you feel might be helpful: ______________________

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Physician Name: ______________________ Signature: ______________________

Address: ______________________

Telephone No.: (_____) _____ - __________ Fax No.: (_____) _____ - __________ Date: ______________ (MM/DD/YY)

PLEASE SUBMIT COMPLETED CLAIM FORM TO:

The Canada Life Assurance Company
Creditor Insurance
330 University Avenue Toronto ON M5G 1R8
Fax No.: 416.552.6557 • Email: tor_bp_creditorclaims@canadalife.com

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