BALANCE PROTECTION INSURANCE
STATEMENT OF CLAIM

CLAIM TYPE: (PLEASE CHECK ONE)

☐ Life * ☐ Disability ☐ Critical Illness ** ☐ Hospitalization*** ☐ Involuntary **** Unemployment

* Please attach a CERTIFIED COPY OF THE DEATH CERTIFICATE or FUNERAL DIRECTOR'S STATEMENT
** Please provide copies of ANY PATHOLOGY REPORTS (Cancer), if applicable
*** Please attach a copy of the Discharge Summary
**** Please attach your RECORD OF EMPLOYMENT, EI ACCEPTANCE LETTER and copies of EI BENEFIT STATEMENTS. If self-employed, please provide proof of income.

INSURED INFORMATION:

First name: _____ Last name: _____ Date of birth: _____ (MM/DD/YYYY)

Authorized user's first name: _____ Last name: _____ Date of birth: _____ (MM/DD/YYYY)

Unique client ID: _____

Mailing address

Street and number: _____

City/Town: _____ Province: _____ Postal code: _____

Telephone no(s): (_____) _____ - _____ (_____) _____ - _____

Name of person claiming for Life benefits: _____ Relation to deceased: _____

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.

Signature of claimant: _____ Date: _____ (MM/DD/YYYY)

EMPLOYER STATEMENT - TO BE COMPLETED BY EMPLOYER

FOR INVOLUNTARY UNEMPLOYMENT AND DISABILITY BENEFITS ONLY.

First name of employee: _____ Last name of employee: _____

Employee occupation: _____

Date of hire: _____ (MM/DD/YYYY) Last day worked: _____ (MM/DD/YYYY) Reason for unemployment: _____

Reason for unemployment: _____

Please indicate if: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Contract

Average hours worked per week: _____ Expected return to work date (if applicable): _____ (MM/DD/YYYY)

Employer name: _____

Employer address: _____

Telephone no.: (_____) _____ - _____ Fax no.: (_____) _____ - _____

Signed: _____ Date: _____ (MM/DD/YYYY)

Completed by: _____ Position: _____

canada life™

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN

FOR DISABILITY, HOSPITALIZATION OR CRITICAL ILLNESS BENEFITS (HEART ATTACK, STROKE OR CANCER).
(ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT).

First name of patient: _____ Last name of patient: _____ Date of birth: _____ (MM/DD/YYYY)

Diagnosis: _____

Date symptoms first appeared or accident happened: _____ (MM/DD/YYYY)

Date patient became disabled: _____ (MM/DD/YYYY) Expected return to work date: _____ (MM/DD/YYYY)

Has patient ever had the same or similar condition? ☐ Yes ☐ No

If yes, state when, if applicable, the duration and describe. _____

_____

Is disability due to pregnancy? ☐ Yes ☐ No Please describe the complication. _____

_____ Expected date of delivery: _____ (MM/DD/YYYY)

Has the patient been hospitalized? ☐ Yes ☐ No Length of stay: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

Name and address of hospital: _____

Hospital Telephone No.: _____

Physician's remarks: _____

Physician name: _____ Signature: _____

Address: _____

Telephone no.: (_____) _____ - _____ Fax no.: (_____) _____ - _____ Date: _____ (MM/DD/YYYY)

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN

FOR LIFE BENEFITS (ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT).

First name of deceased: _____ Last name of deceased: _____

Date of birth: _____ (MM/DD/YYYY) Date of death: _____ (MM/DD/YYYY)

Manner of death: ☐ Natural Causes ☐ Accident ☐ Suicide ☐ Homicide

Cause of death: _____

How long did the deceased have the disease or condition? _____

Physician remarks: _____

Physician name: _____ Signature: _____

Address: _____

Telephone no.: (_____) _____ - _____ Fax no.: (_____) _____ - _____ Date: _____ (MM/DD/YYYY)

PLEASE SUBMIT COMPLETED FORM TO:

THE CANADA LIFE ASSURANCE COMPANY
CREDITOR INSURANCE
TANGERINE BALANCE PROTECTION INSURANCE CLAIMS DEPARTMENT
330 UNIVERSITY AVENUE
TORONTO ON M5G 1R8
TOLL FREE NO. 1.866.995.8705 FAX NO. 416.552.6557
EMAIL: tor_bp_creditorclaims@canadalife.com

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