ACCOUNT BALANCE PROTECTION INSURANCE
STATEMENT OF CLAIM

Clear Form

CLAIM TYPE: (PLEASE CHECK ONE)

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

* Please attach a CERTIFIED COPY OF THE DEATH CERTIFICATE or FUNERAL DIRECTOR'S STATEMENT
** Please provide copies of ANY PATHOLOGY REPORTS, 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)

Unique Client ID.: _____

MAILING ADDRESS:

Number and Street: _____

City/Town: _____ Province: _____ Postal Code: _____

E-mail: _____

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

Name of Person claiming for Life benefits: _____ Relation to Deceased: _____

SIGNATURE OF AUTHORIZATION TO OBTAIN INFORMATION – TO BE SIGNED BY INSURED

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

- When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information.
- Your information 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.

Who has access to your information:

- 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 and to persons to whom you have granted access.
- In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada.
- Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

- Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes.
- This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.

The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

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

If you want to know more:

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 or refer to www.canadalife.com.

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

canada life™

EMPLOYER'S 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: _____

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

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

Employer Name: _____

Employer Address: _____

E-mail: _____

Telephone No.: ( )____ - _____ Fax No.: ( )_____ -_____

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

Completed By: _____ Position: _____

ATTENDING PHYSICIAN'S STATEMENT – TO BE COMPLETED BY PHYSICIAN

FOR DISABILITY, HOSPITALIZATION, ACCIDENTAL DISMEMBERMENT 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 If so, 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: _____

E-mail: _____

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's Remarks: _____

Physician Name: _____ Signature: _____

Address: _____

E-mail: _____

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

PLEASE SUBMIT COMPLETED FORM TO:

THE CANADA LIFE ASSURANCE COMPANY
CREDITOR INSURANCE
ACCOUNT BALANCE PROTECTION INSURANCE CLAIMS DEPARTMENT
330 UNIVERSITY AVENUE, TORONTO, ONTARIO, CANADA M5G 1R8
TOLL FREE NO.: 1-877-789-4182
FAX NO.: 416 -552-6557
E-MAIL: tor_bp_creditorclaims@canadalife.com