Your critical illness claim

This document outlines the requirements to apply for your individual critical illness benefits.

Step 1: Claimant's initial statement

- Complete the *Claimant's initial statement* (form **K883**).[1] If additional space is required, write on a separate page.
- The completed claimant's initial statement provides us with notice of your critical illness claim. It also provides us with general information about you and your health.

Step 2: Physician's initial statement

- Have your doctor complete the *Physician's initial statement* (form **70-0720**) located at canadalife.com.[2]
- To avoid delays with the review of your claim we recommend that you include copies of all relevant medical records with the physician's initial statement, such as chart notes, consultation reports and test results.
- The completed physician's initial statement provides us with information regarding your medical condition and treatment plan.
- Your doctor can mail, email or fax the completed physician's initial statement directly to The Canada Life Assurance Company (Canada Life) at the contact information below.

Contact information

The Canada Life Assurance Company
Living Benefits Claims
PO Box 6000, Winnipeg MB R3C 3A5

Email: lbclaims@canadalife.com
Fax: 1-204-946-4030
Toll-free: 1-877-280-7527
Visit canadalife.com

Our responsibility

The review of your claim will begin when we receive your *Claimant's initial statement* and *Physician's initial statement*.

Once we receive the claimant's initial statement, we will send you an acknowledgment letter or email which will provide you with your claim specialist's name and contact information. Your claim specialist will contact you within 10 business days from having received the claimant's initial statement to let you know what you can expect throughout the claim process and to obtain any further information that may be required.

Email disclaimer

The protection of confidential client information is very important to our organization. Email, although very convenient, is not a secure medium for the exchange of confidential personal information. We cannot guarantee the security of correspondence via email. If you wish to receive correspondence by email, please note that we can take no responsibility for ensuring that the information will remain confidential and not be intercepted or read by others, either over the internet or through the receiving computer. By giving us your email address in 1.6, you acknowledge and agree that you are aware of the risk and are accepting this risk.

Protecting your personal information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at 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. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, store, use and disclose the personal information to investigate and assess your claims with Canada Life. For a copy of our Privacy Guidelines or if you have any questions about our personal information policies and practices (including with respect to service providers), write to Canada Life Chief Compliance Officer or refer to canadalife.com.

1 In providing any claim forms, Canada Life does not admit any liability or waive any of its rights.
2 You are responsible for any fees related to the completion of the forms and any other medical information provided.

canada life™

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Claimant's initial statement

Critical illness claim

1. Insured's information

1.1 Policy numbers: _____

1.2 Name of insured: _____

1.3 Date of birth (day/month/year): _____

1.4 Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

1.5 Phone number: _____

1.6 Email address (optional): _____
See *Email disclaimer*.

2. Claim details

2.1 Describe the nature and extent of the insured's critical illness:

2.2 Date symptoms began (day/month/year): _____

2.3 Date of first medical consultation (day/month/year): _____

2.4 Date of diagnosis (day/month/year): _____

2.5 Date of surgery, if applicable (day/month/year): _____

2.6 Were you admitted to a hospital? ☐ Yes, provide details below ☐ No

Name of hospital: _____

Date admitted (day/month/year): _____

Date discharged (day/month/year): _____

2.7 Have you had the same or similar condition in the past?

☐ Yes, provide dates and physicians consulted below ☐ No

2.8 Have any of your parents or siblings suffered from a similar or related illness?

☐ Yes, provide details below ☐ No

Indicate relationship, nature of illness and the age at which the illness was diagnosed:

3. Medical consultations

3.1 Provide details of any doctors or specialists who have been consulted.

Name of doctor or specialist: _____

Specialty: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Date first consulted (day/month/year): _____

Name of doctor or specialist: _____

Specialty: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Date first consulted (day/month/year): _____

Name of doctor or specialist: _____

Specialty: _____

Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Date first consulted (day/month/year): _____

4. Other insurance

4.1 Indicate if you have other critical illness coverage (whether or not your claim has been approved):

Name of insurer: _____

Policy number: _____

Amount of benefit: $ _____

Date of issue (day/month/year): _____

Name of insurer: _____

Policy number: _____

Amount of benefit: $ _____

Date of issue (day/month/year): _____

Name of insurer: _____

Policy number: _____

Amount of benefit: $ _____

Date of issue (day/month/year): _____

5. Authorization and signature

Before we can process your claim for benefits, you must read this agreement and provide a handwritten signature in the box below.

Sharing your personal information

We collect, use and disclose your personal information to:

- Investigate and assess your claim
- Administer your claim
- Audit the assessment of the claim

We may collect and exchange your personal information with these persons or groups when relevant and necessary for the purpose above:

- Healthcare and rehabilitation providers
- Independent medical specialist
- Insurance and reinsurance companies
- Administrators of government benefits and of other benefit programs
- Any person having knowledge of you or your health
- Other organizations or service providers working with us
- **Optional:** Insurance advisor associated with this policy. If you agree, please provide the advisor's name and contact information.

  Name of advisor: _____

  Phone number or email address: _____

Do you wish for Canada Life to deliver any benefit cheque payable in connection with this claim to your insurance advisor so they can deliver the cheque to you?

☐ Yes ☐ No, send cheque directly to me

Protecting your privacy

We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. This information about you may include medical and psychiatric information. Canada Life may use service providers located within or outside Canada. The only persons with access to the information are:

- People working at Canada Life and those we've authorized, who need the information to do their jobs and manage your claim
- Those whom you've given access
- Those authorized by law both within Canada and in any other jurisdiction where your personal information is held

By signing below, you confirm that:

- You have read, understand, and agree with the contents of this form and authorize us to collect and disclose your personal information.
- Subject to legal and contractual restrictions, your authorization is valid for the duration of your claim or until you cancel it in writing.
- All statements you have made about your claim are true and complete.
- A photocopy or electronic copy of this authorization is as valid as the original.

Date signed (day/month/year): _____

Name of insured: _____

Policy numbers: _____

X _____

Signature of **insured**