Canada Life

ScotiaLife Financial®

Scotiabank
ScotiaPlan Loan Disability Claim Forms

Statements required for claim submission:

1. **Branch Statement**
2. **Claimant Statement**
3. **Employer Statement**
4. **Attending Physician's Statement**

Important:

- Please ensure all the above documents are fully completed and included in your Claim submission. Missing documents may delay the assessment of your claim.
- The completed package can be sent to Canda Life, PO Box 158, Station M, Halifax NS B3J 3V2, or faxed to 902.423.8169, or emailed to HalifaxCreditor@canadalife.com.
- Until a claims decision has been reached, claimants are responsible for maintaining their regular loan payments with Scotiabank. If approved, there is a 30 day waiting period whereby no benefits are payable. Thereafter, benefits are due on the first loan payment due date following the end of the waiting period and are prorated for any periods that are less than a full payment period. All approved benefit payments are payable to Scotiabank only.
- Upon receipt of the initial claim forms and review, Canada Life will advise you in writing of your claim status and/or if any additional information is required.

Canada Life

1. BRANCH STATEMENT

BANK INSTRUCTIONS:

1. Branch to verify that the ScotiaPlan Loan is insured by Canada Life.
2. Complete Loan Information in the field below for each insured ScotiaPlan Loan.
3. **Important - To avoid delays in claim processing, please ensure the original Loan Insurance Application and copies of subsequent renewal letters/insurance applications are attached.**
4. Provide completed Branch Statement and Insurance Documents to the Claimant to submit with the remainder of their claim form statements.

NAME OF INSURED

First name: _____ Last name: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION	**Loan No. 1**	**Loan No. 2**	**Loan No. 3**
Insured loan number (Transit number followed by Loan Number)			
Date of original loan	Year-Month-Day	Year-Month-Day	Year-Month-Day
Date the term began on current loan	Year-Month-Day	Year-Month-Dayy	Year-Month-Day
Current loan term *(number of months)*			
Maturity Date of current term:			
Amortization period at date the term began on current loan *(number of months)*			

Loan Payment Amount: $ _____

Frequency of Payment:
- ☐ Monthly — Specify day of month: _____ (for last day of month, state "end of month")
- ☐ Bi-weekly — Specify day of week: _____
  Next scheduled payment date: _____ (Year-Month-Day)
- ☐ Weekly — Specify day of week: _____
- ☐ Semi-monthly — Specify days of month: _____

Is this loan a renegotiation (ie. amended, extended, rewritten, refinanced of a previous disability insured Loan?

	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐

If "yes", please provide <u>both</u> of the following:

1. Previous loan number			

2. A copy of the previous ScotiaPlan Loan Insurance Application/Automatic Renewal Letter.
   This will speed up claim processing if the client is eligible for Prior Coverage Recognition.

BRANCH MAILING ADDRESS

Name of Authorized Branch Officer: (please print) _____

Number and street/PO box no.: _____

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

Direct telephone number: (_____) _____ - _____ Branch fax number: (_____) _____ - _____

Branch location transit number: _____

Signature of Authorized branch officer: _____ Date: (Year-Month-Day) _____

PLEASE SUBMIT COMPLETED FORM TO:

Canada Life Assurance Company
Creditor Insurance Office - Halifax
PO Box 158, Station M
Halifax NS B3J 3V2
Fax to: 902.423.8169 **Email to: HalifaxCreditor@canadalife.com**

Canada Life

2. CLAIMANT STATEMENT

Instructions for Borrowers Claiming Credit Disability Benefits

1. Before submitting your claim for consideration refer to your Scotia Plan Loan Insurance Application and Certificate of Insurance which outlines the policy provisions. Particular attention should be given to the sections entitled “Limitations” and “Exclusions”. Note also that disability benefits are not paid for the first 30 days of disability (waiting period). Benefit payments are made on your regular Loan payment date.
2. Please ensure all claim forms are completed in detail by you, your employer and your doctor. Incomplete information will cause delays in processing your claim.
3. If It appears that your disability will not last beyond your waiting period, please do not have your doctor or employer complete the form. If it’s certain it will last longer than your waiting period, have your doctor and employer complete the form as close to the end of your waiting period as Is convenient.
4. If your claim is accepted, Canada Life will pay your monthly benefit payment to the Bank as long as you remain disabled and continue to meet the policy requirements. On approval, a “Claim Action Form” will be forwarded to you indicating the payment made on your behalf and the date to which payment will continue, based on the evidence submitted. You will also be advised when further medical evidence is required. At that time, a “Supplementary Claim Form” will be sent to you (along with a return envelope) for completion by you and your doctor. As soon as you return to work, advise Canada Life immediately to ensure that any remaining benefits due are properly assessed.
5. If your claim is denied Canada Life will advise you directly by letter Indicating the reason.
6. Where there are further requirements pertaining to the processing of your claim, you will be advised by a Claim Action Form or letter.

CLAIMANT STATEMENT FOR CREDIT DISABILITY BENEFITS (Please Print)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First name: _____ Last name: _____

Date of birth: (Year-Month-Day) _____ Sex: ☐ Male ☐ Female

Mailing address: _____

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

Telephone no.: (_____) _____ - _____

If retired/unemployed at commencement of disability, please provide name of previous Employer and outline the job duties below under Brief Job Description.

Brief job description

_____

Name and address of employer prior to date last worked: _____

Telephone no.: (_____) _____ - _____

Last day worked: (Year-Month-Day) _____ Date returned to work: (Year-Month-Day) _____

Expected date of return to work: (Year-Month-Day) _____

Cause of disability: ☐ Sickness ☐ Accident If accident provide date of accident: (Year-Month-Day) _____

Accident location: ☐ Home ☐ Work ☐ Elsewhere (specify): _____

How did accident happen?

_____

If diability is due to a motor vehicle accident, provide the following information:

Were you a ☐ Driver ☐ Passenger?

If Driver, were you under the influence of alcohol/substance? ☐ Yes ☐ No

Were any charges laid? ☐ Yes ☐ No

Date illness/injury began: (Year-Month-Day) _____ Nature of illness or injury? _____

Describe present treatment (medication, diets, physiotherapy, etc.)

_____

Have you been hospitalized? ☐ Yes ☐ No If “yes”, name of hospital: _____

Dates hospitalized: From (Year-Month-Day) _____ To (Year-Month-Day) _____

CLAIMANT STATEMENT FOR CREDIT DISABILITY BENEFITS (con't)

Have you ever had same or similar condition? ☐ Yes ☐ No

If "yes", state when and describe:

Names and addresses of all physicians consulted for present illness within the last year:

Are you currently receiving or will you become entitled to receive any benefits by reason of your disability from any of the following:

☐ Workers' Compensation Board ☐ Canada or Quebec Pension Plan ☐ Other Government Plan (U.I.C., etc.)

☐ Any group coverage *(provide company name)* _____

THIRD PARTY AUTHORIZATION

If you wish to authorize someone other than yourself (such as a family member or friend) to communicate with The Canada Life Assurance Company on your behalf with respect to your claim, please complete this Authorization Section of the claim form.

Communication will be limited to matters related to the claim for benefits. This authorization shall remain valid for the duration of the claim for benefits or until otherwise revoked by you. A reproduction of this authorization shall be as valid as the original.

I, _____ , authorize Canada Life to communicate personal information that relates to my claim for benefits with:

Name of authorized party: (please print) _____

Relationship to Insured: _____

Address of the authorized party:

Telephone no.: (_____) _____ - _____

Signature of Insured: _____ Date: (Year-Month-Day) _____

SIGNATURE AND AUTHORIZATION - Must be completed by the 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 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, use and disclose the personal information to administer the group benefits plan, including investigating and assessing your claim.

I authorize Canada Life, my creditor and / or plan sponsor, any healthcare or rehabilitation provider, 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 Insured: _____ Date: (Year-Month-Day) _____

Canada Life

3. EMPLOYER STATEMENT

To be completed by the EMPLOYER for whom you last worked prior to the disability commencement date.

NOTE: If Retired prior to disability, please complete the form based on the occupation you last worked.
If Self-Employed, form is to be completged by yourself. Please also indicate if you are still engaged in any operational duties of your business.

NAME AND ADDRESS OF EMPLOYER

Name: _____

Street name and number: _____

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

Commencement date of employment: (Year-Month-Day) _____ Date last worked: (Year-Month-Day) _____

Reason for discontinuing work: _____

Date expected to return to work: (Year-Month-Day) _____ ☐ Full-time ☐ Part-time

OR

Date returned to work: (Year-Month-Day) _____ ☐ Full-time ☐ Part-time

Occupation as of last day worked: _____

*If seasonal position, please indicate number of years or seasons that the employee has worked for you consecutively: _____

TYPE OF POSITION

☐ Full-time

☐ Part-time, *specify number of hours worked per week* ➡

☐ Seasonal, *specify number of hours worked per week* ➡

No. of hours

From			To		
Year	Month	Day	Year	Month	Day

Brief outline of job duties and physical requirements *(eg. amount of standing, bending, lifting, etc.)*

(Please provide copy of formal job description if available.)

Is this employee covered under a plan *(other than Workers' Compensation)* providing group disability coverage for your employees? ☐ Yes ☐ No

If "yes", provide name of insurance company and policy number:

I certify that according to the records of this organization, the above information is correct.

Name of authorized employer representative: _____ Title: _____

Signature of authorized employer representative: _____ Date: (Year-Month-Day) _____

Telephone No.: (_____) _____ - _____

PLEASE SUBMIT COMPLETED FORM TO:

Canada Life Assurance Company
Creditor Insurance Office - Halifax
PO Box 158, Station M
Halifax NS B3J 3V2
Fax to: 902.423.8169 **Email to: HalifaxCreditor@canadalife.com**

Canada Life™

CLAIM FOR DISABILITY

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN
(ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT)
Part I - to be completed by patient.
Part II - to be completed by doctor.

PART I - CLAIMANT AUTHORIZATION (PLEASE PRINT)

First Name of the Patient: _____ Last Name of the Patient: _____

Date of Birth: (Year-Month-Day) _____ Address: _____

Signature of Claimant: _____

I hereby authorize the release of any information, in respect of this claim to Canada Life. I also understand that, unless prohibited by legislation, I am responsible for any charge made for the completion of this form.

PART II - ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

How long have you been patient's physician? Months _____ Years _____

Date patient medically seen and placed off work due to incapacity: (Year-Month-Day) _____

Name of physician / hospital consulted on that day if other than yourself: _____

1. CAUSE OF DISABILITY

Please list primary medical condition causing disability followed by any additional conditions contributing to disability in order of severity.

Diagnosis	Date Symptoms Started (Year-Month-Day)	Date of First Visit / Consultation (Year-Month-Day)
1. (Primary)		
2.		
3.		
4.		

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

If yes, please outline when and treatment provided. _____

For disabilities resulting from an accident, please indicate date of accident: (Year-Month-Day) _____

Is disability caused by a motorized vehicle accident? ☐ Yes ☐ No

If yes, are you aware if patient was operating the vehicle under the influence of alcohol? ☐ Yes ☐ No

If yes, please provide copies of the tests confirming the blood alcohol levels if available.

For disabilities relating to complications of pregnancy, please indicate expected date of confinement: (Year-Month-Day) _____

2. DEGREE OF IMPAIRMENT

If hospital confined:

Name of HOSPITAL: _____ Date of Admission: _____ Date of Discharge: _____

Physical Impairment (if applicable): Please outline specific physical restrictions i.e standing, lifting, walking, bending, etc.

Cardiac Impairment (if applicable):

☐ Class 1 (no limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood Pressure (last visit) Systolic _____ Diastolic _____ Height / Weight _____

Mental / Nervous Impairment (if applicable):

Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF.

Axis 1 (Primary) _____

Axis 2 _____

Axis 3 _____

Axis 4 _____

Axis 5 - Current GAF _____ Lowest GAF in past year _____

Are you aware of any other factors contributing to the patient's inability to perform their work duties?

☐ Workplace Issues ☐ Family ☐ Finances ☐ Legal Issues ☐ Other: _____

3. TREATMENT

Outline Treatment Details:			
Medication(s)	**Date(s) Prescribed (Year-Month-Day)**	**Dosage(s)**	**Condition prescribed for:**

Frequency of visits: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: _____

To your knowledge, is patient following recommended treatment program. ☐ Yes ☐ No

If no, please provide details: _____

For disabilities relating to mental health, has a referral been made to a Psychologist or Psychiatrist? ☐ Yes ☐ No

If no, please indicate why: _____

4. PROGRESS / PROGNOSIS

Patient has:

☐	Recovered	Please indicate date recovered / able to return to work	Date: (Year-Month-Day)
☐	Improved	Please indicate date you expect patient will return to work	Date: (Year-Month-Day)
☐	No Improvement	What will be the next avenue of medical treatment? Are any referrals pending?	
☐	Prognosis Unknown	Please Estimate: ☐ 1-3 months ☐ 4-6 months ☐ Over 6 months ☐ Never	

Do you feel your patient could return to modified duties? ☐ Yes ☐ No
If yes, complete the following:

Start Date: (Year-Month-Day)	Hours per Day:	Days per Week:	Expected Duration:
Limitations if any:			

Please attach any tests or consultation reports relating to the cause of disability that you feel would be helpful in the assessment of your patient's claim.

Name of attending physician (please print): _____ Specialty: _____

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

Address (number, street, city, province, postal code):

_____

Signature of Physician: _____ Date (Year-Month-Day): _____

Clear

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Canada Life Assurance Company
Creditor Insurance Office - Halifax
PO Box 158, Station M
Halifax NS B3J 3V2
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