

SCOTIA CREDIT CARD PROTECTION  
CRITICAL ILLNESS / HEALTH CRISIS PROTECTION CLAIM

**Please be advised that until this claim is approved, the joint cardholder remains responsible for making the minimum payment to the credit card account.**

## INSTRUCTIONS FOR COMPLETION OF THIS CLAIM PACKAGE

In order to be eligible for these benefits you must suffer from one of the covered illnesses under this plan: cancer, heart attack, stroke, coronary by-pass surgery, coma, blindness, deafness or paralysis.

**If you wish to claim under multiple credit cards - please complete just one claim form package. You can enter the applicable credit card(s) number(s) in the form below.**

In order for us to review your claim for eligibility, you must provide ALL of the following:

1. The enclosed Claimant Statement form fully completed and signed by the Claimant
2. The enclosed Attending Physician Statement (APS) form fully completed and signed by the Attending Physician or Specialist plus any applicable test results. Refer to APS for detailed information. **If you are unable to have your Doctor complete the form at this time due to the COVID-19 restrictions, kindly complete the form yourself to the best of your ability in addition to attaching copies of any doctor's notes, medical documentation to support your diagnosis.**
3. A copy of the Scotia Credit Card Statement:
  - Issued in the month of diagnosis of the condition being claimed
  - And the first statement issued immediately after the diagnosis of your condition

If you do not have these statements, copies can be requested through your local Scotia Bank branch or Scotia Bank VISA Centre. These copies must accompany the claim forms you are submitting to us.

Failure to submit ALL of the required information as outlined above will result in a delay in your claim.

PLEASE SUBMIT ALL COMPLETED CLAIM FORMS AND CLAIM INFORMATION BY MAIL, EMAIL OR BY FAX TO CHUBB LIFE INSURANCE COMPANY OF CANADA

MAIL:

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500, P.O. Box 139,  
Commerce Court Postal Station Toronto,  
Ontario M5L 1E2

EMAIL: creditcardclaims@chubb.com

FAX: 416-368-0641

Chubb. Insured.<sup>SM</sup>



**SCOTIA CREDIT CARD PROTECTION CLAIM FORM  
CRITICAL ILLNESS / HEALTH CRISIS PROTECTION  
CLAIMANT STATEMENT**

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500  
P.O. Box 139, Commerce Court Postal Station  
Toronto, Ontario M5L 1E2  
O +1.416.594.2627 or +1.877.772.7797  
F +1.416.368.0641  
creditcardclaims@chubb.com

CLAIM INFORMATION		
Title:	Full Name:	
Phone #:		
Address:		
City:	Province:	Postal Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer/Non-Binary <input type="checkbox"/> Other/Prefer Not to Disclose	Date of Birth: (MM/DD/YYYY)	
Scotia Credit Card No.:	Email Address:	
Additional Scotia Credit Cards No(s):		

<b>Please select the Critical Illness/Health Crisis disease being claimed:</b> <input type="checkbox"/> Blindness <input type="checkbox"/> Deafness <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Attack <input type="checkbox"/> Coma <input type="checkbox"/> Paralysis <input type="checkbox"/> Coronary Artery Bypass Surgery <input type="checkbox"/> Stroke		
<b>Please describe the nature and extent of your illness:</b>		
<b>On what date were you diagnosed?:</b> (MM/DD/YYYY)		
<b>If applicable, on what date was surgery performed? :</b> (MM/DD/YYYY)		
<b>On what date did symptoms first commence?</b> (MM/DD/YYYY)		
<b>Please describe these symptoms:</b>		
<b>On what date did you first consult a medical practitioner in connection with your illness?</b> (MM/DD/YYYY)		
<b>Name of Physician:</b>	<b>Phone #:</b>	
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Have you undergone any tests or investigations related to the diagnosis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes, provide details and dates:</b>		
<b>Have you previously suffered from, or received treatment for a similar or related condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes, please provide details and dates:</b>		



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CLAIMANT STATEMENT**

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**MEDICAL CONSULTATIONS**

<b>Name of your Family Physician:</b>		
<b>How long have you been his/her Patient?</b>		
<b>Phone #:</b>		
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Please provide any details of any other doctors or specialists who have been consulted in connection with your illness:</b>		
<b>Name:</b>		<b>Phone #:</b>
<b>Address:</b>		<b>City:</b>
<b>Province:</b>	<b>Postal Code:</b>	<b>Date Seen: (MM/DD/YYYY)</b>
<b>Name:</b>		<b>Phone #:</b>
<b>Address:</b>		<b>City:</b>
<b>Province:</b>	<b>Postal Code:</b>	<b>Date Seen: (MM/DD/YYYY)</b>
<b>If you have been treated at a hospital or similar institution, please provide the following information:</b>		
<b>Name of Hospital:</b>		<b>City or Town:</b>
<b>Date of Admission: (MM/DD/YYYY)</b>		<b>Date of Discharge: (MM/DD/YYYY)</b>
<b>Name of Hospital:</b>		<b>City or Town:</b>
<b>Date of Admission: (MM/DD/YYYY)</b>		<b>Date of Discharge: (MM/DD/YYYY)</b>

**Please confirm you have included a copy of the following documents in addition to this form in your claim submission package:**  
(see Instruction Sheet for more information):

SIGNED ATTENDING PHYSICIAN/SPECIALIST STATEMENT (Page 4)

COPY OF SCOTIA CREDIT CARD STATEMENTS:

Issued in the month of diagnosis of the condition being claimed

The first statement issued immediately after the diagnosis of your condition

**Claimant's Certification:** The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

**Privacy Notice:** I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Chubb Insurance and/or Chubb Life Insurance, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. The Insurer will establish a claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law. If I have the right to access the information, access will be given to me or such persons as I may authorize. I understand that in some instances, the employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and my personal information may be subject to the laws of those foreign jurisdictions. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

To find out more about the Chubb Privacy Policy or our privacy practices please visit [chubb.com/ca](http://chubb.com/ca) or send a written request to: Privacy Officer, Chubb, 199 Bay Street - Suite 2500, P.O. Box 139, Commerce Court Postal Station, Toronto, Ontario M5L 1E2.

**Authorization:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Chubb Insurance/Chubb Life Insurance, or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Name (please print) \_\_\_\_\_

Claimant's Signature: \_\_\_\_\_ Date (MM/DD/YYYY): \_\_\_\_\_

**By completing and submitting this form, I agree to all the declarations and attestations made herein.**



**SCOTIA CREDIT CARD PROTECTION CLAIM FORM  
CRITICAL ILLNESS / HEALTH CRISIS PROTECTION  
ATTENDING PHYSICIAN'S STATEMENT**

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500  
P.O. Box 139, Commerce Court Postal Station  
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O +1.416.594.2627 or +1.877.772.7797  
F +1.416.368.0641  
creditcardclaims@chubb.com

**THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION**

<b>Physician's Name (Please Print):</b>		
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Telephone Number:</b>	<b>Fax Number:</b>	

<b>Patient's Name:</b>	<b>Date of Birth:</b> (MM/DD/YYYY)
<b>Diagnosis:</b>	
<b>Date Symptoms First Appeared:</b> (MM/DD/YYYY)	<b>Exact Date of Diagnosis:</b> (MM/DD/YYYY)
<b>Has the patient ever had the same or similar condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If Yes, state when, if applicable, the duration and describe.</b>	
<b>Has the patient been hospitalized?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Length of Stay:</b>
<b>Name of Hospital:</b>	<b>Hospital Telephone Number:</b>

Physician's Signature: \_\_\_\_\_ Date: (MM/DD/YYYY) \_\_\_\_\_

**By completing and submitting this form, I agree to all the declarations and attestations made herein.**

**Please attach copies of all specialist consultation notes and Admission/discharge records relating to the cause of claim. For the following conditions – please ensure attached documentation includes but is not limited to:**

**Heart Attack:** ECGs from day of event and lab results supporting diagnosis.

**Stroke:** Diagnostic evidence supporting stroke diagnosis and current neurological deficits. Must be evidence of permanent neurological deficit for at least 30 consecutive days.

**Cancer:** Diagnostic evidence to confirm malignant neoplasm including relevant pathology report(s).

**Paralysis:** Detailed neurological findings to clarify extent of paralysis with medical evidence that paralysis has continued for at least 60 consecutive days

**Coronary Artery Bypass:** Operative or discharge reports confirming Coronary Artery Bypass Surgery.

**Blindness:** The diagnosis must be made, in writing, by a Doctor who is a certified ophthalmologist and the condition must be considered permanent and incurable.

**Coma:** Medical evidence by a Neurologist clarifying level of consciousness. Please note coma must persist for at least 96 consecutive hours.

**Deafness:** Means the permanent loss of hearing in one or both ears, with an auditory threshold of more than 90 decibels in each ear.