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

T +1.800.668.7092
F +1.416.221.1685
ScotiaJobLossClaims@chubb.com

SCOTIA CREDIT CARD PROTECTION
JOB LOSS OR STRIKE / LOCKOUT CLAIM

INSTRUCTIONS FOR COMPLETION OF THIS CLAIM PACKAGE

Please be advised - you are responsible for continuing to make your ongoing minimum monthly payments throughout the duration of your claim.

Job Loss: In order to be eligible for these benefits you must be laid off or terminated by your employer (or if Self Employed, have declared bankruptcy). You must have been employed/working for at least 180 consecutive days and working at least 20 hours per week prior to your Job Loss. Furthermore, you must be registered and eligible to receive Employment Insurance benefits. The Claimant must have become unemployed on or before his or her 70th birthday to claim for Job Loss benefits.

If you are Self Employed: In order to be eligible for these benefits you must have been employed for at least 180 consecutive days and working at least 20 hours per week prior to your Job Loss. The monthly Job Loss benefit will be paid only if a self-employed person is declared bankrupt as a result of a petition filed against him or her by a creditor under the Bankruptcy and Insolvency Act (Canada).

Definition of Self-Employed Persons - For the purposes of this Job Loss benefit a person is considered to be self-employed or to have had self-employment, if he or she worked for income to be received from a trade or profession in which he or she was engaged, a partnership in which he or she was a partner, his or her own business, or a private company or other entity in which he or she had an ownership interest.

Strike / Lockout:
In order to be eligible for these benefits, you must be employed for at least 24 consecutive weeks immediately prior to the date of Strike or Lockout.

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

In order to review your **Job Loss or Strike/Lockout** claim for eligibility, you must provide **ALL** of the following:

1. If you are employed by a business – Provide the enclosed claim form (Page 2) completed by yourself and your employer, verifying active employment prior to layoff/ termination or strike/lockout. **If not possible to obtain Employer Statement due to COVID-19, please complete Employer section of form to the best of your ability and submit without Employer signature**.

   If Self Employed – Complete Forms on Page 3 & 4 of this document.

2. JOB LOSS:
   - Copy of your Record of Employment(s) – supporting you worked a minimum of 180 consecutive days
   - Layoff notice
   - Your E.I.C approval letter and proof of receipt of all E.I.C. payments received to date. **If you are unable to obtain E.I.C. due to COVID-19, please submit proof of receipt of all CERB benefits received to date (in addition to ROE/Layoff notice).**

   If Self Employed – In lieu of the documents mentioned above, please provide the following:
   - Proof of Bankruptcy/Insolvency (eg. Court Filing)
   - Documentation of income for a period of 180 days, up to date of bankruptcy or business shutdown
   - Completion of enclosed Unemployment Declaration Form (p.4 of this package).

   STRIKE/LOCKOUT:
   - Copy of your Record of Employment(s) – supporting you worked at least 24 consecutive weeks
   - Strike/Lockout notice

3. A copy of the following Scotia Credit Card Statements:
   - Issued in the month of layoff/termination or strike/lockout
   - The first statement issued immediately after the date of layoff/termination or strike/lockout

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.

CHUBB®

SCOTIA CREDIT CARD PROTECTION CLAIM FORM
JOB LOSS OR STRIKE/LOCKOUT
CLAIMANT STATEMENT & EMPLOYER 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 +1.800.668.7092
F +1.416.221.1685
ScotiaJobLossClaims@chubb.com

CLAIMANT STATEMENT - TO BE COMPLETED BY THE INSURED

Title:	**Name:**	**Scotia Credit Card No.:**	
Additional Scotia Credit Cards No(s):			
Address:			
City:		**Province:**	**Postal Code:**
Phone #:		**Email Address:**	
Date of Birth: (MM/DD/YYYY)		**Gender:** ☐ **Male** ☐ **Female** ☐ **Genderqueer/Non-Binary** ☐ **Other/Prefer Not to Disclose**	
Name of Last Employer:		**Occupation:**	
Employer Address:			
Date of Hire: (MM/DD/YYYY)		**Last Day Worked:** (MM/DD/YYYY)	
Date Notified of Impending Termination / Layoff: (MM/DD/YYYY)			

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

☐ YOUR LAYOFF/TERMINATION OR STRIKE/LOCKOUT NOTICE
☐ COPY OF RECORD OF EMPLOYMENT
☐ COPY OF CORRESPONDENCE FROM E.I.C. CONFIRMING THE STATUS OF YOUR CLAIM (or CERB documentation if EIC not available).
☐ COPY OF SCOTIA CREDIT CARD STATEMENTS:
- ☐ Issued in the month of layoff/termination or strike/lockout
- ☐ The first statement issued immediately after the date of layoff/termination or strike/lockout

EMPLOYER STATEMENT - TO BE COMPLETED BY THE EMPLOYER

Date notified of Impending Termination / Layoff / Strike / Lockout: (MM/DD/YYYY)		
Reason for Unemployment:		
Date of Hire: (MM/DD/YYYY)	**Last Day Worked:** (MM/DD/YYYY)	
Hours Worked / Week:		
I hereby declare that the above information is concerning _____ and is true to the best of my knowledge.		
Company:		
Name:	**Position:**	
Address:		
City:	**Province:**	**Postal Code:**
Telephone Number:	**Fax Number:**	
Email Address:		

Employer's Signature: _____ Date: (MM/DD/YYYY) _____

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 Company of Canada, 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 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 Signature: _____ Date: (MM/DD/YYYY) _____

By completing and submitting this form, I agree to all the declarations and attestations made herein.
Please submit this form via email to ScotiaJobLossClaims@chubb.com.

CHUBB®

SCOTIA CREDIT CARD PROTECTION CLAIM FORM
JOB LOSS (SELF EMPLOYED PERSONS)
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 +1.800.668.7092
F +1.416.221.1685
ScotiaJobLossClaims@chubb.com

CLAIMANT STATEMENT - TO BE COMPLETED BY THE INSURED

Title:	**Name:**	**Scotia Credit Card No.:**	
Additional Scotia Credit Cards No(s):			
Address:			
City:		**Province:**	**Postal Code:**
Phone #:		**Email Address:**	
Date of Birth: (MM/DD/YYYY)		**Gender:** ☐ **Male** ☐ **Female** ☐ **Genderqueer/Non-Binary** ☐ **Other/Prefer Not to Disclose**	
Name of Business:		**Occupation:**	
Business Registration No:			
Business Address:			
Date of Enforced Business Shut Down or Date of Bankruptcy: (MM/DD/YYYY)			

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

☐ PROOF OF BANKRUPTCY/INSOLVENCY (eg. COURT FILING)
☐ DOCUMENTATION OF INCOME FOR A PERIOD OF 180 DAYS UP TO DATE OF BANKRUPTCY
☐ COMPLETION OF UNEMPLOYMENT DECLARATION FORM (see next page)
☐ COPY OF SCOTIA CREDIT CARD STATEMENTS:
- ☐ Issued in the month of bankruptcy
- ☐ The first statement issued immediately after the date of bankruptcy (if available)

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 Company of Canada, 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 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 Signature: _____ Date: (MM/DD/YYYY)_____

By completing and submitting this form, I agree to all the declarations and attestations made herein.
Please submit this form via email to ScotiaJobLossClaims@chubb.com.

CHUBB®

UNEMPLOYMENT DECLARATION

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.800.668.7092
F +1.416.221.1685
E ScotiaJobLossClaims@chubb.com

I, _____ hereby declare that I am still neither employed nor self-employed and have not received any remuneration of any kind from employment or self-employment.

I declare that I am actively seeking employment. Listed below are three companies which I have contacted for employment in the last 30 days:

1. Company Name:

Contact Person:

Phone Number:

Date of Contact:

2. Company Name:

Contact Person:

Phone Number:

Date of Contact:

3. Company Name:

Contact Person:

Phone Number:

Date of Contact:

If I obtain employment or self-employment, I will immediately contact Chubb Life Insurance Company of Canada to advise of my return to work.

I agree to repay to Chubb Life Insurance Company of Canada any benefits paid that relate to a period subsequent to the date of my return to employment or self-employment.

Claimant's Signature: _____ Date: _____

By completing and submitting this form, I agree to all the declarations and attestations made herein.
Please submit this form via email to ScotiaJobLossClaims@chubb.com.