Scotiabank
Scotia Mortgage / Line of Credit Protection Claim Package

Important:

Before submitting your claim for consideration, please refer to your Scotia Mortgage or Scotia Line of Credit Protection Certificate of Insurance which outlines the policy provisions, limitations and restrictions.

- Please ensure **ALL** documents are fully completed for the type of Scotia Mortgage or Scotia Line of Credit Protection benefit you are claiming. Missing documents may delay the assessment of your claim.

  For Life claims: Please note a completed Attending Physician's Statement is required in addition to a copy of the Proof of Death certificate. This is required to etablish the cause of death. A copy of a Coroner's report can also be provided.

  For Terminal Illness claims: Please note a Terminal Illness is an illness that has been determined by a Doctor in writing to likely result in death within one year of the diagnosis date.

  For Critical Illness claims: Please ensure your physician has included with the Attending Physician's Statement the medical reports and test results that are required to support the diagnosis and date diagnosed. The Attending Physician's Statement outlines the required documents.

  For Disability claims: Please note that if your claim is beyond the 150 day submission period, you may be required to provide at your own expense additional medical reports to support the period of disability. In such cases, we suggest submitting your Attending Physician's Statement, along with copies of your medical chart records that are dated throughout the period of time you are claiming benefits. If insured with another disability carrier, providing a copy of your claim file may be sufficient to support your period of claim. For Disability benefits, if approved, benefits are payable to Scotiabank and become due following a 60 day qualifying period starting on the first loan payment due date following the end of your qualifying period. The claim payment will be pro-rated if a Disability benefit is payable for a portion of a regular payment. No benefits are payable for the qualifying period. Frequency of payment is based upon your regular Mortgage account payment due date or your regular monthly payment due date for Lines of Credit. There is a 24 month maximum benefit for any one period of disability and a 48 month lifetime maximum.

- For Life and Terminal Illness claims, if approved, the benefit is a lump sum benefit payable to Scotiabank once the claim assessment is complete.
- Upon receipt of the initial claim forms and initial review, Canada Life will advise you in writing of your claim status and/or if any additional information is required to complete the claim assessment.
- Until a claims decision has been reached, you are responsible for maintaining the required payments with Scotiabank.
- The completed claim package, required medical documents and the Financial Loan Statement provided to you by the bank can be forwarded to:

  Canada Life Assurance Company
  Creditor Insurance Claims
  330 University Avenue
  Toronto, ON M5G 1R8

  Or faxed to: 416.552.6557 or 1.844.870.0176
  Or emailed to: SCOTIACLMS@canadalife.com

  For inquiries regarding the completion of the forms, please contact us at 1.800.387.2671.

328-DI CAN-2/18

Canada Life™

Scotia Mortgage / Line of Credit Protection Statement of Claim

ScotiaLife Financial®

CLAIM TYPE:

☐ Life ☐ Critical Illness ☐ Terminal Illness ■ Disability

Mortgage Policy	Mortgage Number	Mortgage Balance Owing (not required for Disability claims)		Line of Credit Policy	Line of Credit Number	Line of Credit Balance Owing
60350		$		60220		$
		$				$
		$				$

INSURED INFORMATION: (PLEASE PRINT)

☐ Mr. ☐ Mrs. ■ Ms.

First Name: _____ Last Name: _____ Date of Birth: _____ (mm/dd/yyyy)

Mailing Address: _____ (Street and Number)

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

Home Telephone No.: _____ _____ - _____ Mobile Telephone No.: _____ _____ - _____

Email Address: _____ (Please Print)

Name and Address of the Insured's General Practitioner: _____

_____

Name and Address of any other physicians or hospitals consulted by Insured:

FOR LIFE CLAIMS: (PLEASE PRINT)

☐ Mr. ☐ Mrs. ☐ Ms.

Name of Person Claiming: _____ Relationship to Deceased: _____

Date of Death of the deceased: _____ (mm/dd/yyyy)

Mailing Address: _____

Telephone No.: _____ _____ - _____

Email Address: _____ (Please Print)

NOTE: If no family physician has been indicated above for the insured, please provide name and address of any known physicians or walk in clinics the deceased may have consulted. In some cases, Provincial Medical Records may be required upon receipt of the claim.

Name of Physician / Walk in Clinic: _____

Address: _____

Name of Physician / Walk in Clinic: _____

Address: _____

Name of Physician / Walk in Clinic: _____

Address: _____

Please continue to back of this form and complete Signature of Authorization section.

FOR DISABILITY CLAIMS: (PLEASE PRINT)

Last day worked: (mm/dd/yyyy) _____ Date returned to work: (mm/dd/yyyy) _____

Expected date of return to work: (mm/dd/yyyy) _____

Date illness/injury became disabling: _____

Date placed off work by a medical doctor: _____

Cause of Disability: ☐ Sickness ☐ Accident

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

How did the accident happen?

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

If yes, describe: _____

If disability 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

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 (UIC etc.) ☐ Any group coverage

FOR DISABILITY, CRITICAL ILLNESS OR TERMINAL ILLNESS CLAIMS - 3rd Party Authorization: (PLEASE PRINT)

If you wish to designate a representative to correspond and/or make claim on your behalf with Canada Life, please complete the information below. I understand that Canada Life will exchange my personal information with my representative to the same extent they would with me, personally.

☐ Mr. ☐ Mrs. ☐ Ms.

Name of Representative: _____

Address: _____ Relationship: _____

Telephone No.: _____ _____ - _____

Name of Insured: _____ Signature of Insured: _____
(Please print)

Date: _____

SIGNATURE OF AUTHORIZATION TO OBTAIN INFORMATION - TO BE COMPLETED BY INSURED (or ESTATE if applicable):

At **The Canada Life Assurance Company**, 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 or Authorized Representative: _____ Date: _____
(please print) (mm/dd/yyyy)

TO BE SIGNED BY INSURED (or ESTATE if applicable): _____

Note: If signing as an Authorized Representative please confirm the manner of Authorization.(If required, proof of authorization may be requested).

☐ Executor/Administrator of Estate ☐ Power of Attorney ☐ Co-Borrower ☐ Other _____
(Please Specify)

PLEASE SUBMIT COMPLETED FORM TO:

Canada Life Assurance Company
Creditor Insurance Claims
330 University Avenue
Toronto, ON M5G 1R8
Fax to: 416.552.6557 or 1.844.870.0176
Email to: SCOTIACLMS@canadalife.com

Canada Life™

Employer Statement
Disability

ScotiaLife Financial®

EMPLOYER STATEMENT - Must be completed by your current Employer

Employer's mailing address (Number and Street)	City or Town	Province	Postal Code

Commencement date of employment (mm/dd/yyyy)	Date last worked (mm/dd/yyyy)

Reason for discontinuing work

If layoff, date employee notified (mm/dd/yyyy)

Date expected to return to work (mm/dd/yyyy) ☐ Full-time ☐ Part-time	OR	Date returned to work (mm/dd/yyyy) ☐ Full-time ☐ Part-time

Did employee receive severance? ☐ Yes ☐ No If Yes, date severance ends (mm/dd/yyyy)	Occupation as of last day worked

Type of position

☐ Full-time ☐ Part-time **Specify number of hours worked per week:**	Seasonal, provide inclusive dates of employment (mm/dd/yyyy) From: To:

For a disability claim, brief outline of job duties and physical requirements (e.g.: amount of standing, bending, lifting, sitting, etc.)
Please attach a copy of job description.

Has a claim been submitted to Workers' Compensation? ☐ Yes ☐ No
If Yes, indicate the office address.

Physical Demands of the occupation at the time of disability
Please select or circle the appropriate numbers below for each Job requirement:

0 - never performed
1 - sometimes performed
2 - performed occasionally, less than 1 hour per day
3 - frequent and/or repetitious for 1-3 hours daily
4 - maximum job requirement over 3 hours per day

Sitting	0	1	2	3	4	Gripping	0	1	2	3	4
Standing	0	1	2	3	4	Typing	0	1	2	3	4
Walking	0	1	2	3	4	Climbing	0	1	2	3	4
Bending	0	1	2	3	4	Lifting	0	1	2	3	4
Kneeling	0	1	2	3	4	Pulling	0	1	2	3	4
Carrying	0	1	2	3	4	Pushing	0	1	2	3	4
Reaching:						Lifting, Carrying, Pushing, Pulling:					
Below Shoulder	0	1	2	3	4	0 to 10 lbs	0	1	2	3	4
Above Shoulder	0	1	2	3	4	10 to 25 lbs	0	1	2	3	4
						25 to 50 lbs	0	1	2	3	4
						over 50 lbs	0	1	2	3	4

Name of insurance company *(other than Workers' Compensation)* providing group disability coverage for your employees. Please include Policy Number and contact person.

Insurance Company	Contact Person	Telephone No.

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

Name of authorized officer (please print)	Title	Telephone No.

Signature of authorized officer	Date (mm/dd/yyyy)

Return to Employee

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Canada Life™ ScotiaLife Financial®

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: (mm/dd/yyyy) _____ 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: (mm/dd/yyyy) _____

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 (mm/dd/yyyy)	Date of First Visit / Consultation (mm/dd/yyyy)
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: (mm/dd/yyyy) _____

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: _____

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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: (mm/dd/yyyy)
☐	Improved	Please indicate date you expect patient will return to work	Date: (mm/dd/yyyy)
☐	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: (mm/dd/yyyy)	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 (mm/dd/yyyy): _____

PLEASE SUBMIT COMPLETED FORM TO:

Canada Life Assurance Company
Creditor Insurance Claims
330 University Avenue
Toronto, ON M5G 1R8
Fax to: 416.552.6557 or 1.844.870.0176
Email to: SCOTIACLMS@canadalife.com