

Scotiabank

Scotia Loan Protection - Statement of Claim Package

Important:

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

- Please ensure **ALL** documents are fully completed for the type of Scotia Loan 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 establish 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 Job Loss claims: Please ensure that your Record of Employment filed with Human Resources Development Canada is provided along with proof of receipt of EI benefits. If your claim is accepted - you will be required to provide ongoing proof that you are in receipt of Employment Insurance benefits during the course of your claim.

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 Critical Illness, Job Loss or Disability benefits, if approved, benefits are payable to Scotiabank and become due following a 60 day waiting period, after which benefits are retroactive to the start date of the claim. Please note there is a 12 month lifetime maximum benefit for each type of coverage.
- 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 loan 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 Office - Halifax
PO Box 158, Station M
Halifax NS B3J 3V2

Or faxed to: 902.423.8169

Or emailed to: HalifaxCreditor@canadalife.com

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

CLAIM TYPE: Life / Terminal Illness Disability Critical Illness Job Loss**POLICY NUMBER:** **60335**

Loan Number	Outstanding Balance	Monthly Insured Loan Payment

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: _____

Telephone No(s): _____ - _____ - _____

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 JOB LOSS CLAIMS: (PLEASE PRINT)

Please provide a list of all Employers you have worked for in the six (6) months prior to be laid off along with the dates worked and total hours worked each week: (Attach a page if list is longer)

Name of Employer: _____

Start Date _____ End Date _____ Total hours worked each week _____
(mm/dd/yyyy) (mm/dd/yyyy)

Name of Employer: _____

Start Date _____ End Date _____ Total hours worked each week _____
(mm/dd/yyyy) (mm/dd/yyyy)

- Please also include with your Statement of Claim and Employer's Statement - a copy of your Record of Employment filed with Human Resources Development Canada and copies of any EI benefit stubs received to date.

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 OR JOB LOSS 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 Office - Halifax
PO Box 158, Station M
Halifax NS B3J 3V2
Fax to: 902.423.8169
Email to: HalifaxCreditor@canadalife.com

CLAIM FOR CRITICAL ILLNESS

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN

(ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT.)

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

Diagnosis: _____

Date symptoms first appeared: _____ **Exact** Date of First Diagnosis: _____
(mm/dd/yyyy) (Please include mm/dd/yyyy)

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

If Yes, state when, if applicable, the duration and describe: _____

Has the patient been hospitalized? Yes No Length of stay: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

Name of Hospital: _____ Hospital Telephone No.: _____ - _____

PLEASE INCLUDE THE MEDICAL DOCUMENTS LISTED BELOW REQUIRED TO SUPPORT THE RELEVANT DIAGNOSIS NOTED FOR THIS INSURANCE CLAIM.

Physician's Name _____
(Please Print)

Signature _____ Date _____

Address: _____

Telephone No.: _____ - _____ Fax No.: _____ - _____

Heart Attack: Attach copies of ECG's from day of event that confirm evidence of a new heart attack, in addition to the lab results supporting an elevation of the cardio bio-markers and/or enzymes.

Stroke: Attach copies of diagnostic evidence supporting a Stroke diagnosis and outline the current neurological deficits resulting from the stroke that have been present in excess of 30 days and are considered to be permanent.

Cancer: Attach copies of the diagnostic evidence to confirm the malignant neoplasm including the initial pathology report

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