CHUBB

Unity Managing Underwriters Ltd.
P.O. Box 1097, Station B
Willowdale, Ontario, M2K 3A2
T +1.800.668.7092
F +1.416.221.1685
E SCCPClaims@umu.net

SCOTIA CREDIT CARD PROTECTION
CRITICAL ILLNESS / HEALTH CRISIS PROTECTION CLAIM

Please be advised that minimum payments must continue to be remitted to the credit card account.

INSTRUCTIONS FOR COMPLETION OF THIS CLAIM PACKAGE

In order to be eligible for this benefit you must be diagnosed with one of the covered illnesses under this plan: cancer, heart attack, stroke, coronary artery bypass 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 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 and any applicable test results. Refer to APS for detailed information.
3. A copy of the Scotia Credit Card Statement:
   - Issued in the month of diagnosis of the illness being claimed
   - And the first statement issued immediately after the diagnosis of your illness

If you do not have these statements, copies can be requested through your local Scotiabank branch or Scotiabank 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 UNITY MANAGING UNDERWRITERS LIMITED.

Unity Managing Underwriters Ltd. is acting as a Third Party Administrator ("TPA") and handling these claims on behalf of Chubb Insurance or Chubb Life Insurance Company of Canada.

MAIL:
Unity Managing Underwriters Ltd.
P.O. Box 1097, Station B
Willowdale, Ontario, M2K 3A2

EMAIL: SCCPClaims@umu.net

FAX: 416-221-1685

Scotia Line of Credit Insurance: Please note that Chubb Life Insurance Company of Canada does not administer benefits for **Scotia Line of Credit Insurance Protection**. If you wish to submit a claim for your Line of Credit account, please contact Scotiabank at 1-855-753-4272.

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

Unity Managing Underwriters Ltd.
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CLAIM INFORMATION		
Title:	**Full Name:**	
Phone #:		
Address:		
City:	**Province:**	**Postal Code:**
Gender: ☐ **Male** ☐ **Female** ☐ **Genderqueer/Non-Binary** ☐ **Other/Prefer Not to Disclose**	**Date of Birth:** (MM/DD/YYYY)	
Scotia Credit Card No.:	**Email Address:**	
Additional Scotia Credit Card No(s):		

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

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

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

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
- ☐ 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 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. Please submit this form via email to SCCPClaims@umu.net

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

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

Physician's Name (Please Print):		
Address:		
City:	**Province:**	**Postal Code:**
Telephone Number:	**Fax Number:**	

Patient's Name:	**Date of Birth:** (MM/DD/YYYY)
Diagnosis:	
Date Symptoms First Appeared: (MM/DD/YYYY)	**Exact Date of Diagnosis:** (MM/DD/YYYY)
Has the 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:**
Name of Hospital:	**Hospital Telephone Number:**

Physician'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 SCCPClaims@umu.net

Please attach copies of all specialist consultation notes and diagnostic reports 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.