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

T +1.800.668.7092
F +1.416.221.1685
SCCPClaims@umu.net

SCOTIA CREDIT CARD PROTECTION
DISABILITY CLAIM

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

INSTRUCTIONS FOR COMPLETION OF THIS CLAIM PACKAGE

***** PLEASE NOTE: IF YOUR LOSS OCCURRED PRIOR TO OCTOBER 17, 2020, THE EMPLOYMENT ELIGIBLITY REQUIREMENT IS 180 DAYS *****

In order to be eligible for these benefits you must be totally disabled from performing the essential duties of your job because of a sickness, injury, mental illness or nervous disorder for a period of at least 30 consecutive days. You must have been employed for at least 90 consecutive days and working at least 20 hours per week before your period of disability.

Any benefit payable under any one of the insured events shall not be payable under another insured event for the same cause. If you are claiming for both hospitalization and disability for the same cause, the benefit paid shall be limited to the highest amount

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. a) The enclosed Employer Statement form fully completed and signed by the Employer and copy (or copies) of your Record(s) of Employment (ROE) – supporting you worked at least 90 consecutive days. **If you cannot obtain the completed Employer Statement, please complete the details in the form as best as possible and provide ROE(s).**

   b) **If Self-Employed:** The enclosed Self- Employed Statement form fully completed and provide proof of self-employment/ income for 90 consecutive days up to the date you became disabled.

3. The enclosed Attending Physician Statement form fully completed and signed by the Attending Physician or Specialist along with any applicable test results.

4. A copy of the Scotia Credit Card Statement:
   - Issued in the month your disability commenced
   - Issued the month immediately after your disability commenced
   - In addition - Please provide original receipts for any purchases made prior to your date of disability but not yet appearing on your credit card statement.

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.

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SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
CLAIMANT STATEMENT

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THIS SECTION TO BE COMPLETED BY THE INSURED			
Title:	**Name:**	**Scotia Credit Card No.:**	
Additional Scotia Credit Card No(s):			
Phone #:		**Email Address:**	
Address:			
City:		**Province:**	**Postal Code:**
Gender: ☐ **Male** ☐ **Female** ☐ **Genderqueer/Non-Binary** ☐ **Other/Prefer Not to Disclose**		**Date of Birth:** (MM/DD/YYYY)	
Date of Accident or Sickness: (MM/DD/YYYY)		**Nature of Accident of Sickness:**	
If accident, state when, where and how:			
Date first unable to work: (MM/DD/YYYY)		**Date of first medical attendance:** (MM/DD/YYYY)	
Date returned to work: (MM/DD/YYYY)		**Date of expected return to work:** (MM/DD/YYYY)	
Have you had same or similar condition? ☐ **No** ☐ **Yes, describe:**			
Name of Physician:		**From:** (MM/DD/YYYY)	**To:** (MM/DD/YYYY)
Address:			
Name of Physician:		**From:** (MM/DD/YYYY)	**To:** (MM/DD/YYYY)
Address:			
Name of Hospital (In Patient):		**From:** (MM/DD/YYYY)	**To:** (MM/DD/YYYY)
Address:			
Have you applied for or are you receiving? ☐ **C.P.P./Q.P.P** ☐ **Employer Disability** ☐ **Automobile Ins.** ☐ **W.C.B./W.S.I.B.** ☐ **Other (Specify):**			

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)**:**

☐ COPY OF RECORD OF EMPLOYMENT – Supporting you worked at least 90 consecutive days
☐ ENCLOSED EMPLOYER STATEMENT – If Self-Employed – see below.
☐ ENCLOSED ATTENDING PHYSICIAN STATEMENTS AND APPLICABLE TEST RESULTS
☐ COPY OF SCOTIA CREDIT CARD STATEMENTS:
  ☐ Issued in the month your disability commenced
  ☐ Issued in the month immediately after your disability commenced
☐ Please provide original receipts for any purchases made prior to your date of disability but not yet appearing on your credit card statement.

SELF-EMPLOYED PERSON – In addition to the above – please complete/provide the following:
☐ ENCLOSED SELF-EMPLOYED STATEMENT
☐ If you are self-employed, please provide proof of self-employment/income for 90 consecutive days up to the date you became disabled.

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 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

IMPORTANT:
Note that until this claim is approved you remain responsible for making the minimum payment to your account.
You are responsible for the minimum payment due resulting from any purchases made after your date of disability.

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SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
EMPLOYER STATEMENT

Unity Managing Underwriters Ltd.
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EMPLOYER STATEMENT – TO BE COMPLETED BY EMPLOYER OF THE CLAIMANT:

THIS SECTION TO BE COMPLETED BY THE EMPLOYER		
Name of Employer:		
Occupation:		
Date of Hire: (MM/DD/YYYY)	**Hours Worked/Week:**	
Last Day Worked (Prior to Sick Leave): (MM/DD/YYYY)		
I hereby declare that the above information concerning _____ **and his/her employment is true to the best of my knowledge.**		
Company:		
Name:	**Position:**	
Address:		
City:	**Province:**	**Postal Code:**
Phone #:	**Fax #:**	
Email Address:		

Employer'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

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SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
SELF-EMPLOYED STATEMENT

THIS SECTION TO BE COMPLETED BY THE SELF-EMPLOYED CLAIMANT		
Name of Business:	**Business Registration No:**	
Occupation:		
Effective Date of Business Registration: (MM/DD/YYYY)	**Hours Worked/Week:**	
Last Day Worked (Prior to Sick Leave): (MM/DD/YYYY)		
Business Address:		
City:	**Province:**	**Postal Code:**

Business Owner/Self-Employed 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

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SCOTIA CREDIT CARD PROTECTION CLAIM FORM
DISABILITY
ATTENDING PHYSICIAN'S STATEMENT

Unity Managing Underwriters Ltd.
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THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND FOR CHARGES MADE FOR ITS COMPLETION

Physician's Name:		
Address:		
City:	**Province:**	**Postal Code:**
Phone Number:	**Fax Number:**	

Patient's Name:	**Date of Birth:** (MM/DD/YYYY)
Diagnosis of present condition:	
a) Primary:	
b) Secondary (if applicable):	
c) If appropriate – additional conditions which might affect the duration of disability:	
Has Patient had same or similar condition? ☐ **Yes** ☐ **No**	
If "Yes", state when and describe:	
Is condition due to injury arising out of patent's employment? ☐ **Yes** ☐ **No** ☐ **Unknown**	
If accident, please provide brief description:	
Was Patient hospitalized? ☐ **Yes** ☐ **No**	
Name of Hospital:	
Date of Hospital Admission: (MM/DD/YYYY)	**Date of Discharge:** (MM/DD/YYYY)
If surgery performed, please provide date and describe: (MM/DD/YYYY)	
If referred to you, give name of referring physician:	
Date of first visit for present period of disability: (MM/DD/YYYY)	
Date of latest attendance: (MM/DD/YYYY)	
Were you actively supervising this patent's care during the full period? ☐ **Yes** ☐ **No**	
If "Yes", state frequency of visits. ☐ **Weekly** ☐ **Monthly** ☐ **Other (specify):**	
If condition is due to pregnancy, what is (or was) the expected date of confinement? (MM/DD/YYYY)	

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TOTALLY DISABLED

To the best of my knowledge, the patient has been Totally Disabled (Unable to work) **From:** (MM/DD/YYYY) **To:** (MM/DD/YYYY)
If still disabled, give approximate DATE when patient should be able to return to work. (MM/DD/YYYY)
Or, if indefinite, the estimated number of additional WEEKS before such return:

PARTIALLY DISABLED

How long was or will patient be Partially Disabled? (Able to work part-time at own occupation) **From:** (MM/DD/YYYY) **To:** (MM/DD/YYYY)
How does present condition affect patient's ability to work?

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

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