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
HOSPITALIZATION 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: THE HOSPITALIZATION BENEFIT IS ONLY AVAILABLE IF YOU WERE HOSPITALIZED ON OR AFTER OCTOBER 17, 2020 *****

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.

In order to be eligible for these benefits you must be admitted to and confined in a Hospital in Canada or the continental United States (plus Alaska and Hawaii) as an In-Patient overnight for medical treatment, based on the recommendation of a Physician, due to Accidental Bodily Injury or unforeseen Sickness.

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 copy of the Admission and Discharge summary(or summaries) from the Hospital(s) which clearly identifies your date of admission and date of discharge

3. A copy of the Scotia Credit Card Statement:
   - Issued in the month of hospitalization of the condition being claimed
   - And the first statement issued immediately after hospitalization

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.

UNITY MANAGING UNDERWRITERS LIMITED

Chubb. Insured.℠

CHUBB®

SCOTIA CREDIT CARD PROTECTION CLAIM FORM
HOSPITALIZATION CLAIMANT STATEMENT

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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 Cards No(s):		

Please select the Hospitalization period being claimed:	☐ **Hospitalization for a minimum of 24 consecutive hours but less than 30 consecutive days** ☐ **Hospitalization for a minimum of 30 consecutive days or more**
Please describe the nature and extent of your Hospitalization:	
On what date were you admitted?: (MM/DD/YYYY)	
Was this a scheduled hospitalization: ☐ **Yes** ☐ **No**	
Please describe the reason for your Hospitalization(s):	
If applicable, on what date was surgery performed? : (MM/DD/YYYY)	
On what date were you discharged? : (MM/DD/YYYY)	

Name of Physician:	**Phone #:**	
Address:		
City:	**Province:**	**Postal Code:**
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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CHUBB

**SCOTIA CREDIT CARD PROTECTION CLAIM FORM
HOSPITALIZATION CLAIMANT STATEMENT**

MEDICAL CONSULTATIONS		
Name of your Family Physician:		
How long have you been his/her Patient?		
Phone #:		
Address:		
City:	**Province:**	**Postal Code:**

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)
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)
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)**:**

- ☐ COPY OF THE ADMISSION & DISCHARGE SUMMARY(S) FROM THE HOSPITAL(S);
- ☐ COPY OF SCOTIA CREDIT CARD STATEMENTS:
  - ☐ Issued in the month of hospitalization being claimed
  - ☐ The first statement issued immediately after hospitalization

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