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
STATEMENT OF DEATH CLAIM

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

INSTRUCTIONS FOR COMPLETION OF THIS CLAIM PACKAGE
The enclosed forms should be completed by the Executor/Executrix of the Estate of the deceased.

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 Executor/Executrix of the Estate of the Deceased

2. The enclosed Attending Physician Statement form fully completed and signed by the Attending Physician, Specialist, or Coroner/Medical Examiner

3. Copy of the Death Certificate or a Funeral Director's Certificate of Death and any other pertinent information in relation to this claim

4. Proof of age of the Cardholder (i.e. copy of the birth certificate)

5. A copy of the Scotia Credit Card Statement:
   - Issued in the month of death
   - And the first statement issued immediately after the death
6. Please provide original receipts for any purchases made prior to the insured's date of death but not yet appearing on the 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.

UNITY MANAGING UNDERWRITERS LIMITED

Chubb. Insured.℠

CHUBB®

SCOTIA CREDIT CARD PROTECTION CLAIM FORM
STATEMENT OF DEATH CLAIMANT STATEMENT

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INFORMATION ABOUT THE DECEASED		
Scotia Credit Card No.:		
Additional Scotia Credit Card No(s):		
Title:	**Name of Deceased:**	**Date of Birth:** (MM/DD/YYYY)
Gender of Deceased: ☐ **Male** ☐ **Female** ☐ **Genderqueer/Non-Binary** ☐ **Other/Prefer Not to Disclose**		
Address of Deceased:		
City:	**Province:**	**Postal Code:**
Cause of Death:		
If Accident, state when, where and how:		
Date of Death: (MM/DD/YYYY)	**Onset of Illness:** (MM/DD/YYYY)	
Prior History of Same or Related Illness ☐ **Yes** ☐ **No**		
If yes, describe.		

INFORMATION ABOUT THE CLAIMANT		
Title:	**Name:**	**Phone #:**
Gender: ☐ **Male** ☐ **Female** ☐ **Genderqueer/Non-Binary** ☐ **Other/Prefer Not to Disclose**		
Address:		
City:	**Province:**	**Postal Code:**
Email Address:		
You are claiming as (please check one box): ☐ **Estate Executor/Executrix** ☐ **Assignee** ☐ **Other**		
If other, please specify.		

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.

CHUBB®

SCOTIA CREDIT CARD PROTECTION CLAIM FORM
STATEMENT OF DEATH ATTENDING PHYSICIAN STATEMENT

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

TO BE COMPLETED BY ATTENDING PHYSICIAN	
Attending Physician's Name:	
Address:	
Phone #:	**Fax #:**

Full Name of Deceased:
Date of Birth: (MM/DD/YYYY)
Residence at Death:
Date of Death: (MM/DD/YYYY)
Immediate Cause of Death (Disease, Injury or Complication causing Death):
Time between onset and Death:
List any other significant conditions: (Whether or not related to the cause of Death)
Was an autopsy performed? ☐ **Yes** ☐ **No**
Date of first attendance in last illness: (MM/DD/YYYY)
Date of last attendance in last illness: (MM/DD/YYYY)
Did the deceased receive treatment during the last 5 years from any other physician? ☐ **Yes** ☐ **No**
If yes, please provide the Name and Address for each Physician consulted.

Physician's Signature: _____ Date (MM/DD/YYYY): _____

Specialty: _____

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