Canada Life™

COMMERCIAL CREDIT STATEMENT OF CLAIM FORM

ScotiaLife Financial

CLAIM TYPE:

☐ Life ☐ Disability ☐ Hospitalization ☐ Terminal Illness

POLICY NUMBER: 10650

Business CID #	Basic Coverage Amount	Comprehensive Coverage Amount
	$	$

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): _____ _____ - _____ _____ _____ - _____

Name and Address of the Insured's General Practitioner: _____

Name and Address of any other physicians or hospital's consulted by Insured: _____

COMMERCIAL CREDIT BUSINESS DETAILS: (PLEASE PRINT)

Business Name and Address: _____

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

Mailing Address: _____ Telephone No.: _____ _____ - _____

FOR LIFE CLAIMS: (PLEASE PRINT)

☐ Mr. ☐ Mrs. ☐ Ms.

Name of Person Claiming: _____ Relationship to Deceased: _____

Mailing Address: _____ Telephone No.: _____ _____ - _____

NOTE: If no family physician has been indicated above for the insured, please provide name and address of any known physicians the deceased may have consulted. In some cases, Provincial Medical Records may be required upon receipt of the claim.

Please continue to back of this form and complete Signature of Authorization section.

FOR DISABILITY CLAIMS: (PLEASE PRINT) To be completed by employer

Name of Employer: _____ Date Employed: (mm/dd/yyyy) _____ Date Last Worked: (mm/dd/yyyy) _____

Reason for Date Last Worked: _____

Duties of occupation (please provide formal job description if available): _____

Date employee is expected to return to work: (mm/dd/yyyy) _____

Completed by: (please print) _____ Occupational Title: _____

Signature: _____ Date: (mm/dd/yyyy) _____

Telephone No.: _____ _____ - _____

CONTINUE TO BACK OF FORM

Clear

FOR DISABILITY, HOSPITAL OR TERMINAL ILLNESS 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 SIGNED BY INSURED:

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: _____
(mm/dd/yyyy)

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)

Canada Life™

CLAIM FOR DISABILITY

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN
(ANY FEES FOR THIS INFORMATION MUST BE PAID FOR BY THE CLAIMANT)
Part I - to be completed by patient.
Part II - to be completed by doctor.

PART I - CLAIMANT AUTHORIZATION (PLEASE PRINT)

First Name of the Patient: _____ Last Name of the Patient: _____

Date of Birth: (mm/dd/yyyy) _____ Address: _____

Signature of Claimant: _____

I hereby authorize the release of any information, in respect of this claim to Canada Life. I also understand that, unless prohibited by legislation, I am responsible for any charge made for the completion of this form.

PART II - ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

How long have you been patient's physician? Months _____ Years _____

Date patient medically seen and placed off work due to incapacity: (mm/dd/yyyy) _____

Name of physician / hospital consulted on that day if other than yourself: _____

1. CAUSE OF DISABILITY

Please list primary medical condition causing disability followed by any additional conditions contributing to disability in order of severity.

Diagnosis	Date Symptoms Started (mm/dd/yyyy)	Date of First Visit / Consultation (mm/dd/yyyy)
1. (Primary)		
2.		
3.		
4.		

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

If yes, please outline when and treatment provided. _____

For disabilities resulting from an accident, please indicate date of accident: (mm/dd/yyyy) _____

Is disability caused by a motorized vehicle accident? ☐ Yes ☐ No

If yes, are you aware if patient was operating the vehicle under the influence of alcohol? ☐ Yes ☐ No

If yes, please provide copies of the tests confirming the blood alcohol levels if available.

For disabilities relating to complications of pregnancy, please indicate expected date of confinement: (mm/dd/yyyy) _____

2. DEGREE OF IMPAIRMENT

If hospital confined:

Name of HOSPITAL: _____ Date of Admission: _____ Date of Discharge: _____

Physical Impairment (if applicable): Please outline specific physical restrictions i.e standing, lifting, walking, bending, etc.

Cardiac Impairment (if applicable):

☐ Class 1 (no limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood Pressure (last visit) Systolic _____ Diastolic _____ Height / Weight _____

Mental / Nervous Impairment (if applicable):

Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF.

Axis 1 (Primary) _____

Axis 2 _____

Axis 3 _____

Axis 4 _____

Axis 5 - Current GAF _____ Lowest GAF in past year _____

Are you aware of any other factors contributing to the patient's inability to perform their work duties?

☐ Workplace Issues ☐ Family ☐ Finances ☐ Legal Issues ☐ Other: _____

3. TREATMENT

Outline Treatment Details:			
Medication(s)	**Date(s) Prescribed (mm/dd/yyyy)**	**Dosage(s)**	**Condition prescribed for:**

Frequency of visits: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other:

To your knowledge, is patient following recommended treatment program. ☐ Yes ☐ No

If no, please provide details: _____

For disabilities relating to mental health, has a referral been made to a Psychologist or Psychiatrist? ☐ Yes ☐ No

If no, please indicate why: _____

4. PROGRESS / PROGNOSIS

Patient has:

☐	Recovered	Please indicate date recovered / able to return to work	Date: (mm/dd/yyyy)
☐	Improved	Please indicate date you expect patient will return to work	Date: (mm/dd/yyyy)
☐	No Improvement	What will be the next avenue of medical treatment? Are any referrals pending?	
☐	Prognosis Unknown	Please Estimate: ☐ 1-3 months, ☐ 4-6 months, ☐ Over 6 months, ☐ Never	

Do you feel your patient could return to modified duties? ☐ Yes ☐ No
If yes, complete the following:

Start Date: (mm/dd/yyyy)	Hours per Day:	Days per Week:	Expected Duration:
Limitations if any:			

Please attach any tests or consultation reports relating to the cause of disability that you feel would be helpful in the assessment of your patient's claim.

Name of attending physician (please print): _____ Specialty _____

Telephone No.: _____ _____ - _____

Address (number, street, city, province, postal code):

_____

Signature of Physician: _____ Date: _____

PLEASE SUBMIT COMPLETED FORM TO:

The Canada Life Assurance Company
Creditor Claims
PO Box 158 Station M
Halifax NS B3J 3V2
Tel 1.800.387.2671 Fax 1.902.423.8169