Scotiabank
Scotia Loan Protection - Statement of Claim Package

Important:

Before submitting your claim for consideration, please refer to your Scotia Loan Protection Certificate of Insurance which outlines the policy provisions, limitations and restrictions.

- Please ensure **ALL** documents are fully completed for the type of Scotia Loan Protection benefit you are claiming. Missing documents may delay the assessment of your claim.

  For Life claims: Please note a completed Attending Physician's Statement is required in addition to a copy of the Proof of Death certificate. This is required to etablish the cause of death. A copy of a Coroner's report can also be provided.

  For Terminal Illness claims: Please note a Terminal Illness is an illness that has been determined by a Doctor in writing to likely result in death within one year of the diagnosis date.

  For Critical Illness claims: Please ensure your physician has included with the Attending Physician's Statement the medical reports and test results that are required to support the diagnosis and date diagnosed. The Attending Physician's Statement outlines the required documents.

  For Job Loss claims: Please ensure that your Record of Employment filed with Human Resources Development Canada is provided along with proof of receipt of EI benefits. If your claim is accepted - you will be required to provide ongoing proof that you are in receipt of Employment Insurance benefits during the course of your claim.

  For Disability claims: Please note that if your claim is beyond the 150 day submission period, you may be required to provide at your own expense additional medical reports to support the period of disability. In such cases, we suggest submitting your Attending Physician's Statement, along with copies of your medical chart records that are dated throughout the period of time you are claiming benefits. If insured with another disability carrier, providing a copy of your claim file may be sufficient to support your period of claim.

- For Critical Illness, Job Loss or Disability benefits, if approved, benefits are payable to Scotiabank and become due following a 60 day waiting period, after which benefits are retroactive to the start date of the claim. Please note there is a 12 month lifetime maximum benefit for each type of coverage.
- For Life and Terminal Illness claims, if approved, the benefit is a lump sum benefit payable to Scotiabank once the claim assessment is complete.
- Upon receipt of the initial claim forms and initial review, Canada Life will advise you in writing of your claim status and/or if any additional information is required to complete the claim assessment.
- Until a claims decision has been reached, you are responsible for maintaining the required loan payments with Scotiabank.
- The completed claim package, required medical documents and the Financial Loan Statement provided to you by the bank can be forwarded to:

  Canada Life Assurance Company
  Creditor Insurance Office - Halifax
  PO Box 158, Station M
  Halifax NS B3J 3V2

  Or faxed to: 902.423.8169
  Or emailed to: HalifaxCreditor@canadalife.com

  For inquiries regarding the completion of the forms, please contact us at 1.800.387.2671.

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Canada Life™

Scotia Loan Protection Statement of Claim

ScotiaLife Financial®

CLAIM TYPE:

☐ Life / Terminal Illness ☐ Disability ☐ Critical Illness ☐ Job Loss

POLICY NUMBER: 60335

Loan Number	Outstanding Balance	Monthly Insured Loan Payment

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): _____ _____ - _____ _____ _____ - _____

Email Address: _____
(Please Print)

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

_____

Name and Address of any other physicians or hospitals consulted by Insured:

_____

_____

FOR LIFE CLAIMS: (PLEASE PRINT)

☐ Mr. ☐ Mrs. ☐ Ms.

Name of Person Claiming: _____ Relationship to Deceased: _____

Date of Death of the deceased: _____
(mm/dd/yyyy)

Mailing Address: _____

Telephone No.: _____ _____ - _____

Email Address: _____
(Please Print)

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

Name of Physician / Walk in Clinic: _____

Address: _____

Name of Physician / Walk in Clinic: _____

Address: _____

Name of Physician / Walk in Clinic: _____

Address: _____

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

Clear

FOR JOB LOSS CLAIMS: (PLEASE PRINT)

Please provide a list of all Employers you have worked for in the six (6) months prior to being laid off along with the dates worked and total hours worked each week: (Attach a page if list is longer)

Name of Employer: _____

Start Date _____ (mm/dd/yyyy) End Date _____ (mm/dd/yyyy) Total hours worked each week _____

Name of Employer: _____

Start Date _____ (mm/dd/yyyy) End Date _____ (mm/dd/yyyy) Total hours worked each week _____

- Please also include with your Statement of Claim and Employer's Statement - a copy of your Record of Employment filed with Human Resources Development Canada and copies of any EI benefit stubs received to date.

FOR DISABILITY CLAIMS: (PLEASE PRINT)

Last day worked: (mm/dd/yyyy) _____ Date returned to work: (mm/dd/yyyy) _____

Expected date of return to work: (mm/dd/yyyy) _____

Date illness/injury became disabling: _____

Date placed off work by a medical doctor: _____

Cause of Disability: ☐ Sickness ☐ Accident

Accident Location: ☐ Home ☐ Work ☐ Elsewhere (specify): _____

How did the accident happen?

Have you ever had same or similar condition? ☐ Yes ☐ No

If yes, describe: _____

If disability is due to a motor vehicle accident, provide the following information:

Were you a: ☐ Driver ☐ Passenger

If Driver, were you under the influence of alcohol/substance? ☐ Yes ☐ No

Were any charges laid? ☐ Yes ☐ No

Are you currently receiving or will you become entitled to receive any benefits by reason of your disability from any of the following:

☐ Workers' Compensation Board ☐ Canada or Quebec Pension Plan

☐ Other Government Plan (UIC etc.) ☐ Any group coverage

FOR DISABILITY, CRITICAL ILLNESS OR TERMINAL ILLNESS CLAIMS OR JOB LOSS 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: _____ (Please print) Signature of Insured: _____

Date: _____

SIGNATURE OF AUTHORIZATION TO OBTAIN INFORMATION - TO BE COMPLETED BY INSURED (or ESTATE if applicable):

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: _____
(please print) (mm/dd/yyyy)

TO BE SIGNED BY INSURED (or ESTATE if applicable): _____

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)

PLEASE SUBMIT COMPLETED FORM TO:

Canada Life Assurance Company
Creditor Insurance Office - Halifax
PO Box 158, Station M
Halifax NS B3J 3V2
Fax to: 902.423.8169
Email to: HalifaxCreditor@canadalife.com

Canada Life™

Employer Statement
Disability or Job Loss Claim

ScotiaLife Financial®

EMPLOYER STATEMENT - Must be completed by your current Employer

Employer's mailing address (Number and Street)	City or Town	Province	Postal Code

Commencement date of employment (mm/dd/yyyy)	Date last worked (mm/dd/yyyy)

Reason for discontinuing work

If layoff, date employee notified (mm/dd/yyyy)

Date expected to return to work (mm/dd/yyyy) ☐ Full-time ☐ Part-time	**OR**	Date returned to work (mm/dd/yyyy) ☐ Full-time ☐ Part-time

Did employee receive severance? ☐ Yes ☐ No If Yes, date severance ends (mm/dd/yyyy)	Occupation as of last day worked

Type of position

☐ Full-time ☐ Part-time **Specify number of hours worked per week:**	Seasonal, provide inclusive dates of employment (mm/dd/yyyy) From: To:

For a disability claim, brief outline of job duties and physical requirements (e.g.: amount of standing, bending, lifting, sitting, etc.)
Please attach a copy of job description.

Has a claim been submitted to Workers' Compensation? ☐ Yes ☐ No
If Yes, indicate the office address.

Physical Demands of the occupation at the time of disability
Please circle the appropriate numbers below for each Job requirement:

0 - never performed
1 - sometimes performed
2 - performed occasionally, less than 1 hour per day
3 - frequent and/or repetitious for 1-3 hours daily
4 - maximum job requirement over 3 hours per day

Sitting	0	1	2	3	4	Gripping	0	1	2	3	4
Standing	0	1	2	3	4	Typing	0	1	2	3	4
Walking	0	1	2	3	4	Climbing	0	1	2	3	4
Bending	0	1	2	3	4	Lifting	0	1	2	3	4
Kneeling	0	1	2	3	4	Pulling	0	1	2	3	4
Carrying	0	1	2	3	4	Pushing	0	1	2	3	4
Reaching:						Lifting, Carrying, Pushing, Pulling:					
Below Shoulder	0	1	2	3	4	0 to 10 lbs	0	1	2	3	4
Above Shoulder	0	1	2	3	4	10 to 25 lbs	0	1	2	3	4
						25 to 50 lbs	0	1	2	3	4
						over 50 lbs	0	1	2	3	4

Name of insurance company *(other than Workers' Compensation)* providing group disability coverage for your employees. Please include Policy Number and contact person.

Insurance Company	Contact Person	Telephone No.

I certify that according to the records of this organization the above information is correct.

Name of authorized officer (please print)	Title	Telephone No.

Signature of authorized officer	Date (mm/dd/yyyy)

Return to Employee

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