iA Financial Group

CRITICAL ILLNESS CLAIM FORM

GROUP INSURANCE

Please submit the completed form by:

Mail:

PO Box 4643, Station A
Toronto, Ontario M5W 5E3

Fax:

1-877-781-1583

Note: For increased security, we recommend that you send personal information to iA Financial Group by mail or fax.

POLICYHOLDER'S STATEMENT
PLEASE PRINT IN INK. TO SPEED UP PROCESSING, ANSWER ALL QUESTIONS.

MEMBER INFORMATION

First name _____ Last name _____

Policy no. _____ Certificate no. _____ Division no. _____ Class no. _____

Occupation _____

Date hired (Y Y Y Y M M D D) _____ Effective date of coverage (Y Y Y Y M M D D) _____

Last day worked (Y Y Y Y M M D D) _____ Amount of coverage $ _____

Please indicate any other comments relevant to this claim.

_____

_____

POLICYHOLDER INFORMATION AND STATEMENT

Policyholder's name _____

Address _____ Postal code _____

Telephone _____ Email _____

Authorized person's name _____

I certify the accuracy of the information above.

Authorized signature **X** _____ (Y Y Y Y M M D D) _____

MEMBER IDENTIFICATION (TO BE COMPLETED BY THE MEMBER)

First name _____ Last name _____

Date of birth (Y Y Y Y M M D D) _____ Social insurance number (optional) _____

Address _____ Postal code _____

Telephone _____ Email _____

Policy no. _____ Certificate no. _____

CLAIMANT'S STATEMENT

TO SPEED UP PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

IDENTIFICATION

Claimant: Plan member ☐ Spouse ☐ Dependent child ☐

If you checked spouse or dependent child, specify the following:

First name _____ Last name _____

Date of birth (Y Y Y Y M M D D) _____

CLAIMS AND RELATED DETAILS

1. Please indicate the type of critical illness that you are claiming.

_____

2. Date of illness onset (Y Y Y Y M M D D) _____ Date of surgery (Y Y Y Y M M D D) _____

3. Please give full details of the nature and extent of your illness.

_____

_____

_____

4. Have you previously suffered from, or received treatment for, the same or a similar or related illness?

   No ☐ Yes ☐ If "yes", give full details.

_____

_____

_____

CLAIMS AND RELATED DETAILS (CONTINUED)

5. On what date did you first consult a doctor in connection with your illness?

_____

_____

_____

6. Have you undergone any medical tests since your condition started?

No ☐ Yes ☐ If "yes", provide the following. Attach extra sheets, if necessary.

Medical test	Date (YYYY-MM-DD)	Results

7. Please list all physicians who have treated you or hospitals where you have been treated for this illness. Attach extra sheets, if necessary.

Physician or hospital _____ Date of visit Y Y Y Y M M D D

Address _____ Postal code

Telephone _____

Physician or hospital _____ Date of visit Y Y Y Y M M D D

Address _____ Postal code

Telephone _____

Physician or hospital _____ Date of visit Y Y Y Y M M D D

Address _____ Postal code

Telephone _____

Physician or hospital _____ Date of visit Y Y Y Y M M D D

Address _____ Postal code

Telephone _____

8. Please provide the following information for your family physician.

First name _____ Last name _____

Address _____ Postal code

Telephone _____

CLAIMS AND RELATED DETAILS (CONTINUED)

9. Have any of your blood relatives suffered from a similar or related illness?

   No ☐ Yes ☐ If "yes", provide the following. Attach extra sheets, if necessary.

Relationship of relative	Nature of illness	Date illness was diagnosed (YYYY-MM-DD)

CONFIRMATION AND AUTHORIZATION OF PLAN MEMBER AND CLAIMANT (IF DIFFERENT)

I HEREBY CONFIRM that the information contained in this Claim form for a Critical Illness Benefit is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse or dependent child, **I CONFIRM** that I am authorized to disclose information about them with respect to the claim.

On behalf of myself and my dependents:

1. **I CONSENT** to the release of the information contained in this Claim form to Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, agents, reinsurers and service providers for the purpose of underwriting, administration and processing of the claim; and

   I UNDERSTAND AND AUTHORIZE that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, iA Financial Group will have the right to use and exchange any information related to the claim with any relevant reulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

   I UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

2. **I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, public or private organization or institution to disclose to iA Financial Group, its employees, agents and service providers any information which they may need in the assessment of the claim.

   I AUTHORIZE the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

   I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original. I understand that by furnishing this form and investigating the claim or accepting proofs of the claim, iA Financial Group shall not be held to admit the validity of the claim nor to have waived any of its rights in defence of the claim arising under the Group Policy.

Signature of plan member (mandatory) **X** _____ Y Y Y Y M M D D

Signature of claimant (if different) **X** _____ Y Y Y Y M M D D

LIMITATION PERIOD NOTICE

We are required under certain legislation to advise you that your claim under your group policy is governed by a limitation period that is set out in the Insurance Act or other applicable legislation in your province (e.g. Limitations Act, 2002 (Ontario), Civil Code (Quebec)). This means you cannot sue after a certain period of time has passed. You must obtain your own independent advice in regard to this limitation period.

MEMBER IDENTIFICATION (TO BE COMPLETED BY THE MEMBER)

First name _____ Last name _____

Policy no. _____ Certificate no. _____ Date of birth Y Y Y Y M M D D

ATTENDING PHYSICIAN'S STATEMENT

PLEASE PRINT IN INK AND GIVE TO THE PATIENT.

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST.

Patient first and last name _____

Date of diagnosis Y Y Y Y M M D D Date of illness onset Y Y Y Y M M D D

1. Primary diagnosis _____

2. Secondary diagnosis _____

3. The patient is a: Smoker ☐ Non-smoker ☐

4. For the illnesses or associated symptoms diagnosed, has the patient previously:

   ☐ Received medical treatments Period _____

   ☐ Consulted another physician Period _____

   ☐ Taken medication Period _____

   ☐ Been hospitalized Period _____

   ☐ Undergone examinations Period _____

TREATMENT

1. Medications (name and dosage) _____

_____

2. Has the patient undergone or will the patient undergo:

   a. Examinations or tests? No ☐ Yes ☐ Specify and provide copies of test results _____

   b. Surgery? No ☐ Yes ☐ Day surgery ☐ Type _____ Date Y Y Y Y M M D D

      Surgical procedure _____

   c. Other treatments? No ☐ Yes ☐ Specify _____

   d. Hospitalization? No ☐ Yes ☐ From Y Y Y Y M M D D to Y Y Y Y M M D D

      Name of hospital _____

FOLLOW-UP AND PROGNOSIS

1. Date of first consultation for this illness Y Y Y Y M M D D

2. Next consultation Y Y Y Y M M D D Follow-up frequency _____

3. Referral to another physician? No ☐ Yes ☐

   Name of physician _____

   Specialty _____

IDENTIFICATION OF THE ATTENDING PHYSICIAN

First name _____ Last name _____

General practitioner ☐ Specialist ☐ Other ☐ Specify _____

Address _____ Postal code

Telephone _____ Fax _____

Signature **X** _____ Y Y Y Y M M D D

NOTE: THE MEMBER IS RESPONSIBLE FOR ANY FEES CHARGED TO COMPLETE THIS FORM.