President's Choice FINANCIAL

creditor insurance claim form

Instructions for Life Claim

What information is required for a Life Claim?

- completion of the creditor life insurance claim form and other supporting evidence as requested

Instructions for Disability Claim

What information is required for a Disability Claim?

- completion of the creditor disability or job loss claim form with the following sections completed:
  - Claimant Statement
  - Employer Statement
  - Attending Physician Statement

Instructions for Job Loss Claim

What information is required for a Job Loss Claim?

- a copy of your Record of Employment filed with Human Resources Development Canada, **and**
- completion of the creditor disability or job loss claim form with the following sections completed:
  - Claimant Statement
  - Employer Statement

What happens after a Claim is submitted?

- You will be advised if further information is required to process your claim.
- You are responsible for any payments until the claim is approved. If the claim is approved, the Insurer will pay disability and job loss benefits after the 30 day wait period.
- On approval of your claim, a notice will be sent to you indicating the payment(s) made on your behalf.
- If your claim is denied, the Insurer will advise you in writing.

Do you need more information?

- Refer to your certificate of creditor insurance for information about the benefits, exclusions, limitations and termination of benefits.
- ***Call the Creditor Insurance Helpline at 1-800-465-6020***

Where to send claim(s)

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service,
P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

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creditor life insurance claim form

Deceased's Authorized Representative

Complete the first section on this form as the deceased's authorized representative and give to deceased's family physician for completion. Include original or notarized copy of proof of death and send to Sun Life Assurance Company of Canada, c/o Creditor Insurance Customer Service as instructed below in the "Where to send claim(s)". For accidental death, attach Coroner's Report, Autopsy Report, and Police Accident Report if available. Be sure to retain copies of all documents for your files.

Family Physician

Complete and sign indicated section of this form. Return completed form to the authorized representative.

Where to send claim(s)

Sun Life Assurance Company of Canada c/o Creditor Insurance Customer Service, P.O. Box 3020, Mississauga STN A, Mississauga, ON L5A 4M2

This section to be completed by Deceased's Authorized Representative

Name of Deceased - Surname | First Name | Initial | Gender ☐ M ☐ F

Details of other life insurance of deceased with Sun Life Assurance Company of Canada and policy number

Name of Deceased's Authorized Representative | Relationship to Deceased *(e.g. next of kin, executor/executrix, etc.)*

Address *(number and street)*

City | Province | Postal Code | Telephone Number

I authorize and direct any medical practitioner, hospital or clinic, or medically related facility, insurance company, law enforcement agency or other organization, institution or person that has, or may in the future have, any record or information regarding the above named deceased (including any record or information regarding psychologically related and HIV/AIDS related conditions) to release any such records or information to Sun Life Assurance Company of Canada, Canadian Imperial Bank of Commerce ("CIBC") or any of their designated administrator 's for the purpose of the underwriting process or the adjudication of this claim. A photographic copy of this authorization shall be valid as the original.

Date (DD/MM/YYYY) | Signature

This section to completed by Family Physician

Note: Any charge for completion of this form is the responsibility of the claimant.

Name of Deceased - Surname | First Name | Initial | Date of Birth (DD/MM/YYYY)

Place of Death | Date of diagnosis of condition causing death (DD/MM/YYYY) | Date of Death (DD/MM/YYYY)

Immediate Cause | Contributory Cause(s) | Date of first treatment for condition causing death (DD/MM/YYYY) | Date of Last Treatment (DD/MM/YYYY)

Manner of death ☐ Accident ☐ Suicide ☐ Natural Causes *(please tick appropriate box and provide additional details)*

Was an inquest held? ☐ Yes ☐ No If yes, by whom and what were the findings (attach findings): Was an autopsy performed? ☐ Yes ☐ No

Deceased has been a patient since *(day, month, year)*

Give details of any conditions for which you treated the deceased during the 12 months prior to death whether or not related to the cause of death.

Date	Diagnosis	Treatment Prescribed	Type of Surgery, if any

Name of Family Physician *(please print)* | Telephone Number

Address *(number and street)* | City | Province | Postal Code

Name and Address of any other doctors who, to your knowledge, may have treated the deceased prior to death *(attach note if insufficient space)*

Date (DD/MM/YYYY) | Signature of Family Physician

These statements are true and complete to the best of my knowledge.

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creditor disability or job loss claim claimant statement

Claimant information

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss | First name | Last name | Date of Birth (DD/MM/YYYY)

Mailing address: Number | Street | City | Province | Postal code | Telephone no.

Occupation at date of disability/job loss | Preferred correspondence language ☐ English ☐ French | Self-employed ☐ Yes ☐ No

Employment type ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Temporary | If seasonal, regular months of employment *(day, month, year)* From To

Brief job description

Name and address of employer *(at time of disability/job loss)* | Telephone no.

Last day worked *(day, month, year)* | Date returned to work *(day, month, year)* | Expected date of return to work *(day, month, year)*

If employed by above employer less than 12 months, please provide:

Name and address of previous employer | Telephone no.

First day worked *(day, month, year)* | Last day worked *(day, month, year)*

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

☐ Workers' Compensation Board and Reference No. | ☐ E.I. *(provide date you registered for E.I. benefits)* | ☐ Canada or Quebec Pension Plan

☐ Any other group coverage *(provide company name and policy no.)* | ☐ Individual insurance coverage *(provide company name and policy no.)*

Complete if submitting a disability claim

Cause of disability: ☐ Sickness ☐ Accident | If accident, provide date of accident *(day, month, year)* | Location of accident ☐ Work ☐ Elsewhere (specify):

How did accident happen/cause of disability | If MVA, include police report

Date illness began *(day, month, year)* | Nature of illness or injury

Present treatment *(medication, diets, physiotherapy, etc.)*

Have you been hospitalized for this condition? ☐ No ☐ Yes, name of hospital: | Dates hospitalized *(day, month, year)* From To

Have you ever had same or similar condition? ☐ No ☐ Yes, state when and describe:

Names and addresses of all physicians consulted for present condition within the last year

I certify that the statements in this form are true and complete. I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and exchange information about me (including psychologically related conditions and HIV/AIDS related conditions)needed for underwriting, administration and adjudicating claims and Canadian Imperial Bank of Commerce ("CIBC") for the purpose of administering my claim, under this Group Policy with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout my claim.

Date (DD/MM/YYYY) | Signature

Please submit to:

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service
P.O. Box 3020
Mississauga STN A, Mississauga, ON L5A 4M2

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creditor disability or job loss claim employer statement

Employer Information

To be completed by the Employer for whom you were working at commencement of disability/unemployment.
If unemployed at your date of disability, to be completed by Employer for whom you last worked. If self-employed, to be completed by Claimant.

Name of Employer

Name of Claimant

Mailing address: Number Street City Province Postal code

Commencement date of employment *(day, month, year)*

Date last worked *(day, month, year)*

Reason for discontinuing work

If layoff, date employee notified *(day, month, year)*

Date expected to return to work *(day, month, year)*
☐ Full-time ☐ Part-time

OR

Date returned to work *(day, month, year)*
☐ Full-time ☐ Part-time

Did employee receive severance?
☐ No ☐ Yes, date severance ends *(day, month, year)*

Occupation as of last day worked

Type of position

☐ Full-time, specify number of hours worked per week:

☐ Part-time, specify number of hours worked per week:

Seasonal, provide inclusive dates of employment: *(day, month, year)*
From: To:

For disability claims only - Brief outline of job duties and physical requirements *(e.g.: amount of standing, bending, lifting, sitting, etc.)* Please forward copy of job description.

Has a claim been submitted to WCB?

☐ No ☐ Yes If Yes, indicate the office address.

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

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

Name of authorized officer *(please print)*

Title

Telephone no.
– –

Date (DD/MM/YYYY)

Signature

Please submit to:

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service
P.O. Box 3020
Mississauga STN A, Mississauga, ON L5A 4M2

President's Choice FINANCIAL

attending physician statement disability claim only

Section 1 – Patient Authorization

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss

First name | Last name | Date of Birth (DD/MM/YYYY)

Mailing address: Number | Street | City | Province | Postal code | Telephone no.

I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating my claim and with Canadian Imperial Bank of Commerce ("CIBC") as Administrator under this Plan. I agree that a photocopy of this authorization is as valid as the original.

Date (DD/MM/YYYY) | Signature

Section 2 - Attending Physician Statement *Note: Any charge for completion of this form is the responsibility of the claimant.*

History

Date symptoms first appeared or accident happened *(day, month, year)*

Date patient became disabled *(day, month, year)*

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

Has patient ever had same or similar condition? ☐ No ☐ Unknown ☐ Yes, state when and describe

Is condition considered chronic? ☐ No ☐ Yes, what precipitated absence from work?

Names and addresses of other treating physicians

Cause of disability

Primary *(including any complications)*

Diagnosis

Additional conditions or complications which might affect duration of absence from work

Subjective symptoms

Objective signs *(including results of current x-rays, EKG'S, MRI'S, CATSCANS or laboratory data and any relevant clinical findings)*. Please provide copies.

Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ No ☐ Yes

If relevant, blood pressure at time of latest attendance

Current Functional Limitations

1. **Function**

	Degree of limitation				
	None	Slight	Moderate	Severe	Don't Know
Cognition	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Sensation	☐	☐	☐	☐	☐
Psychological	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐

	Degree of limitation				
	None	Slight	Moderate	Severe	Don't Know
Dexterity	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Please add any other functions limited by the illness or injury:					
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Please indicate max. recommended weight _____ ☐ lb ☐ kg

2. Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the person's ability to work.

3. Were any functional capacity evaluations performed? ☐ No ☐ Yes

If "Yes", state type: _____ When? D D M M Y Y Y Y

continued on reverse

Section 2 - Attending Physician *(continued)*

Treatment

Date of first visit *(day, month, year)*

Date of latest visit *(day, month, year)*

Frequency of visits

☐ Weekly ☐ Monthly ☐ Other *(specify)*

Nature of treatment *(including surgery, physiotherapy and medications prescribed, if any)*

To your knowledge is patient following recommended treatment program? ☐ Yes ☐ No, please comment:

Progress

Has patient

☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

Please comment:

Prognosis

If patient is pregnant, please indicate estimated date of confinement

Is patient now totally disabled from own occupation?

☐ Yes, state date you think patient will be able to resume work: *(day, month, year)*

☐ No, state date patient was able to work :*(day, month, year)*

If indefinite, estimate:

☐ 1 - 3 months ☐ 4 - 6 months ☐ over 6 months ☐ never

Is patient a suitable candidate for some trial employment or rehabilitation?

☐ No ☐ Yes, state date *(day, month, year)*

Has patient been referred to another doctor?

☐ No ☐ Yes, dates referred:

Name (specialty) and address:

Remarks

This form may be mailed directly to Sun Life Assurance Company of Canada or given to the patient at the physician's discretion.

Name of Attending Physician *(please print)*

Specialty

Telephone no. – –

Fax no. – –

Mailing address: Number Street City Province Postal code

Date (DD/MM/YYYY)

Signature

Please submit to:

Sun Life Assurance Company of Canada
c/o Creditor Insurance Customer Service
P.O. Box 3020
Mississauga STN A, Mississauga, ON L5A 4M2